029123

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 02039

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: MARSHALL Lee ALEXANDER | | 2a. DATE OF DEATH MONTH DAY YEAR: 1-24-86 | 2b. HOUR: 9:24 A.M. |
| 3. SEX: M | 4. RACE: B | 5. DATE OF BIRTH MONTH DAY YEAR: 6 6 57 | 6. AGE (IN YEARS LAST BIRTHDAY): 28 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): H.M.H. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): NONE | 12b. KIND OF BUSINESS OR INDUSTRY: Disabled |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Md | Harford | Aberdeen | YES ☒ NO ☐ | 431 Washington St 21001 |

| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |
|---|---|
| Ashby Brown | Emma Tasco |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | N/A | 214 70 8668 | Emma T. Brown | Same As Above |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multisystem failure

DUE TO, OR AS A CONSEQUENCE OF (b) Sickle cell disease

DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic encephalopathy

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did/did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Brian T. Fo | MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | |

22d. PHYSICIAN'S NAME (TYPE OR PRINT) — 22e. ADDRESS

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | Jan. 28, 1986 | Union United Cem. | Aberdeen, Harford, Maryland |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399 | JAN 27 1986 | [illegible] |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please staple or bonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

041017

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 02040

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: CHESTER MIDDLE: F. LAST: AMBROSE

2a. DATE OF DEATH MONTH DAY YEAR: 2-5-86

2b. HOUR: 7:25 A.M.

3. SEX: M

4. RACE: WHITE

5. DATE OF BIRTH MONTH DAY YEAR: APRIL 2, 1907

6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MASS.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD CO. MD.

10. CITY OR TOWN OF DEATH: JOPPA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 610 B HARBORSIDE DR.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED

12b. KIND OF BUSINESS OR INDUSTRY: OFFICE MAN.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD.

13b. COUNTY: HARFORD

13c. CITY OR TOWN: JOPPA

13d. INSIDE CITY LIMITS? YES ☑ NO ☐

13e. STREET ADDRESS / ZIP CODE: 610 B. HARBORSIDE DR. 21085

14. FATHER'S NAME FIRST: SAMUEL MIDDLE: ALFRED LAST: AMBROSE

15. MOTHER'S MAIDEN NAME FIRST: MARGARET MIDDLE: LAST: AUSTIN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 100-07-3942

17. INFORMANT: RUTH A. AMBROSE ADDRESS: SAME AS 13e 21085

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE

DUE TO, OR AS A CONSEQUENCE OF

(b) WIDELY METASTASIZED ADENOCARCINOMA — 6 MONTHS

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): NONE

19a. DATE OF OPERATION: NONE

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: N/A

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): N/A

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET: N/A CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-1-86, 19, to 2-5, 19 86, that (I) (we) last saw the deceased alive on 2-5, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Kate Tully

DEGREE: MD

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-5-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): KATE TULLY MD

22e. ADDRESS: 626 TOWNE CENTRE DR. JOPPA, MD 21085

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 2-8-86

23c. NAME OF CEMETERY OR CREMATORY: NORTH BEVERLY CEM.

23d. LOCATION CITY OR TOWN: BEVERLY COUNTY STATE: MASS.

24. FUNERAL DIRECTOR NAME: CAPITOL FUNERAL SER. ADDRESS: FALLS CHURCH VA.

25a. DATE REC'D. BY REGISTRAR: FEB 10 1986

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

036035

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 86 0204 1

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Lillian MIDDLE: Octavia LAST: Anders | | 2a. DATE OF DEATH MONTH DAY YEAR: 1-27-86 | 2b. HOUR: 1:27AM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: March 2, 1896 | 6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Va | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County, MD. |
| 10. CITY OR TOWN OF DEATH: Bel Air | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bel Air Nursing & Convalescent Center | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Homemaker |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Harford Co | Bel Air | YES ☐ NO ☒ | 1809 Ruff's Mill Road 21014 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST: Thomas MIDDLE: Lee LAST: Hollingsworth ~~Hollinsworth~~ | | 15. MOTHER'S MAIDEN NAME FIRST: Missouri MIDDLE: Ann LAST: Quesenberry | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): — | 16b. SOCIAL SECURITY NO.: 218-09-5359 D | 17. INFORMANT (Daughter) 838-9489 Mrs. Blanche Andress; ADDRESS: 1801 Ruffs Mill Road Bel Air, Maryland 21014 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiac arrest | 1:27 Am |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Senile dementia | yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from Jan 31, 1982 to Jan. 27, 1986, that (I) (we) last saw the deceased alive on Jan 16, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Albert S. C. Sun M.D. | DEGREE; ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: Jan 27, 86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Albert S. C. Sun, M.D | 22e. ADDRESS: 1800 Harford Rd Fallston 21047 | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: January 29, 1986 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Tabor Meth. Ch. Cem. | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Bel Air, Harford Co, Maryland 21014 |
| 24. FUNERAL DIRECTOR: Joseph William Foster; Joseph William Foster | ADDRESS: 50 W. Broadway & Williams St, Bel Air, Maryland 21014 | 25a. DATE REC'D. BY REGISTRAR: JAN 30 1986 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please file pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual circumstances, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 02042

1 - FOR STATE REGISTRAR

029069

REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Linda | SUSAN | Anderson | January 25, 1986 | 12:00 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS: HOURS, MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | NOVEMBER 16, 1956 | 29 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARITAL STATUS | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | Harford MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Havre de Grace | Harford Memorial Hosp | TEACHER | ELEMENTARY SCHOOL |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD | HARFORD | HAVRE de GRACE | YES ☒ NO ☐ | 1126 CHESAPEAKE DR. #13E 21078 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| CHARLES | ALLEN | ANDERSON, JR. | VIRGINIA | | REYBURN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 212 50 3509 | C. ALLEN ANDERSON, JR. | 698 LEWIS STREET, HdG, MD 21078 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of colon.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 1/24/86 | Obstructed colotomy | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 1/21, 19 86, to 1/25, 19 86, that (I) (we) last saw the deceased alive on 1/25, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| J.D. SOMERVILLE | 400 LEWIS ST HAVRE DE GRACE |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| CREMATION | 26JANUARY86 | R. A. FERRIS & COMPANY | WEST CHESTER, PA. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078 | JAN 27 1986 | [signature] |

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

028087

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician and kept for its records.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

BP_____

DHMH-16 30M 2/80 (VRA 15, 4)

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

86 02043

REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: CARL MIDDLE: GODFREY LAST: BIERMAN | | 2a. DATE OF DEATH MONTH DAY YEAR: January 21, 1986 | 2b. HOUR: 10:19 PM |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH 9 DAY 22 YEAR 15 | 6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. |
| 10. CITY OR TOWN OF DEATH: Jarrettsville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1424 Dalewood Drive | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Salesman | 12b. KIND OF BUSINESS OR INDUSTRY: Laundry |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | | Baltimore | YES ☒ NO ☐ | 3128 Fait Avenue 21224 |

| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME |
|---|---|
| FIRST: Henry MIDDLE: Christian LAST: Bierman | FIRST: Molly MIDDLE: LAST: Sunderland |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 216-09-7011 | Mrs. Josephine Weininger | 1424 Dalewood Drive, Jarrettsville, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic cancer of the lung

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Larry Wilson MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| LARRY A. WILSON, MD | 3313 Paper Mill Rd, Phoenix, Md. 21131 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 1-25-86 | Holy Redeemer Cem. | Baltimore | Baltimore | Md. |

| 24. FUNERAL DIRECTOR | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Ann M. Matthews, Matthews Funeral Home, 3021 Eastern Ave., Baltimore, Md. 21224 | JAN 24 1986 | [illegible] |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 020044

020128

1. DECEASED NAME (TYPE OR PRINT) FIRST: Gertrude MIDDLE: E. LAST: Biggs
2a. DATE OF DEATH MONTH DAY YEAR: January 8, 1986
2b. HOUR: 7:30 A.M.
3. SEX: female
4. RACE: Black
5. DATE OF BIRTH MONTH DAY YEAR: 7 7 25
6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford Co MD.
10. CITY OR TOWN OF DEATH: Havre de Grace
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hosp
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired
12b. KIND OF BUSINESS OR INDUSTRY: Government

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Harford
13c. CITY OR TOWN: Havre de Grace
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 4128 Gravel Hill Rd. 21078

14. FATHER'S NAME FIRST MIDDLE LAST: Jeremaih Presbury
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Edna Mae Stansbury
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 213- 20-2111
17. INFORMANT ADDRESS: Eva Williams 551 Alliance St. Havre de Grace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 YRS
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: —

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-21-, 19 85, to 1-8-, 19 86, that (I) (we) last saw the deceased alive on 1-8-, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 1/8/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ASHOK NARANG
22e. ADDRESS: 1131 BEL AIR RD BEL AIR, MD 21014

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 1-13-86
23c. NAME OF CEMETERY OR CREMATORY: St. James United
23d. LOCATION CITY OR TOWN COUNTY STATE: Havre de Grace Harford Md.

24. FUNERAL DIRECTOR NAME ADDRESS: Arnold Beard 353 Fountain St. Havre de Grace, Md.
25a. DATE REC'D. BY REGISTRAR: JAN 16 1986
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

037157

FOR 1- STATE REGISTRAR

17cN 18a+22a 3-11-86 CN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86 02045
REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Mary | C. | hristine Blackstone | 1/ 24/19 86 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| Female | Caucasian | 2/7 / 39 | 46 YRS. | | | 1/ 24/19 86 | 4:17 P M |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Virginia | U.S.A. | | Harford County, MD |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Fallston | Fallston General Hospital | Housewife | Home |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md. | Harford | White Hall | | 2500 Jolly Acres Rd. 21161 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Clarence | | White | | | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 305-36-0364 | Harry H. Blackstone, Jr. | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | PARTIAL |

| 21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE _____ M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 1/26/86

EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Cremation | 1/27/86 | Carroll Crematorion | Hampstead | Carroll | Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| M. Gladden Kurtz III | Jarrettsville Md. | FEB 03 1986 | Julia Davidson Pardee |

DIVISION OF VITAL RECORDS, 2[illegible] W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M

BP 37

DHMH - 17 (VR A15 ME (5))

030023

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

86 002046
REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Charles William Blimline SR. | | 2a. DATE OF DEATH MONTH DAY YEAR: 01 23 86 | 2b. HOUR: 6:35 A M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Nov. 7, 1924 | 6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Baltimore, Md. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD COUNTY MD. |
| 10. CITY OR TOWN OF DEATH: FALLSTON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mech.Engr.Tech. | 12b. KIND OF BUSINESS OR INDUSTRY: US-govt.Ret. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Harford | Joppa | YES [ ] NO [X] | 513 Magnolia Road 21085 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Louis | Frank | Blimline | Ottillia | Alice | Kersch |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WWII | 216-20-3590 | Mrs.Loretta E.Blimline | 513 Magnolia Road Joppa,Md. 21085 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (b) Severe Coronary Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____ that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Dan L Dan | MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | |

22d. PHYSICIAN'S NAME (TYPE OR PRINT): VB 55 — 22e. ADDRESS

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | Jan.26,1986 | Highview Mem.Gardens | Fallston | Harford | Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Howard K. McComas III | Abingdon,Md. 21009 | JAN 28 1986 | Julia Davidson Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

031050

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 86 02047

1. DECEASED NAME (TYPE OR PRINT) — FIRST: SPENCER — MIDDLE: — LAST: Bloxham

2a. DATE OF DEATH — MONTH: 1 DAY: 15 YEAR: 86

2b. HOUR: 5:45 AM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH — MONTH: 9 DAY: 12 YEAR: 1908

6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. — IF UNDER 1 YEAR: MONTHS: DAYS: — IF UNDER 24 HRS.: HOURS: MIN.:

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Balto. Md.

7b. CITIZEN OF WHAT COUNTRY?: U. S. A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Citizens Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired

12b. KIND OF BUSINESS OR INDUSTRY: State of Md. Postal Dept.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Harford

13c. CITY OR TOWN: Havre de Grace

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 415 Market St. 21078

14. FATHER'S NAME — FIRST: John MIDDLE: G. LAST: Bloxham

15. MOTHER'S MAIDEN NAME — FIRST: Annetta MIDDLE: LAST: Nice

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 219-28-6681

17. INFORMANT: Mrs. Helen J. Bloxham, Forest Hill, Md. 21050 — ADDRESS: 1609 Ross Rd.

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) AS CVP

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic brain Syndrom

DUE TO, OR AS A CONSEQUENCE OF (c) Hated Pernicious Diverticulosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET: CITY OR TOWN: COUNTY: STATE:

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. T. Lee — DEGREE: M.D. — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/16/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. T. Lee

22e. ADDRESS: Union Med Clinic

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1-17-1986

23c. NAME OF CEMETERY OR CREMATORY: Belair Mem. Gardens

23d. LOCATION — CITY OR TOWN: Belair COUNTY: Harford STATE: Md.

24. FUNERAL DIRECTOR — NAME: E.F.Lassahn, ADDRESS: 11750 BelairRd.Kingsville, Md. 21087

25a. DATE REC'D BY REGISTRAR: JAN 27 1986

25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, medical examiner must be notified.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

017160

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 86 02048

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: ELSIE Margaret BRADFIELD

2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH DAY YEAR: 1-12-86 19

2b. HOUR: M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: May 2, 1916

6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS.

IF UNDER 1 YR. MONTHS DAYS

IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 1-12-86 19

2d. HOUR: 5:45P

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.

10. CITY OR TOWN OF DEATH: Fallston

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Minister

12b. KIND OF BUSINESS OR INDUSTRY: Religion

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Pennsylvania

13b. COUNTY: Lancaster

13c. CITY OR TOWN: Leola

13d. INSIDE CITY LIMITS? YES [ ] NO [ ]

13e. STREET ADDRESS: 75 Laura Lee Blvd. 17540

14. FATHER'S NAME FIRST MIDDLE LAST: William Leonard Bradfield

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Bessie Virginia Shinnick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 214-05-3359

17. INFORMANT: Grace E. Bradfield

ADDRESS: 3558 N. Chatham Road Ellicott City, MD. 21043

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

8120

IMMEDIATE CAUSE (a) Multiple injuries

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: 4:45PM 1-12-86

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): driver of auto/auto collison

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): hgwy.

21f. LOCATION STREET: Rt. 136@165 CITY OR TOWN: Plyesville, COUNTY: STATE: Maryland

22a. I certify that I took charge of the remains described above, held on Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: Margarita A. Korell M.D.

TITLE (SPECIFY): Assistant MEDICAL EXAMINER

DATE SIGNED: 1-14-86

EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D.

ADDRESS: 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1/16/86

23c. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery

23d. LOCATION CITY OR TOWN: Baltimore COUNTY: STATE: Maryland

24. FUNERAL DIRECTOR: Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228

25a. DATE REC'D. BY REGISTRAR: JAN 14 1986

25b. REGISTRAR'S SIGNATURE

BP

DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL ON ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

031089

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 02049

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: FRANK MIDDLE: James LAST: Bragg | | 2a. DATE OF DEATH MONTH DAY YEAR: JANUARY 18, 1986 | 2b. HOUR: 12:59 A.M. |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: July 30, 1910 | 6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hosp. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer | 12b. KIND OF BUSINESS OR INDUSTRY: Various |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Harford | Havre de Grace | YES ☒ NO ☐ | 100 Revolution Street/21078 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| John | Henry | Bragg | Oma | Iotha | Hall |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | N/A | 218-09-7890 | Anna Mae Dickey | 801 Cocoanut Ct. Apt.F, Bel Air,MD 21014 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular suffering

DUE TO, OR AS A CONSEQUENCE OF (c) Shy Drager syndrome

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

| 22b. SIGNATURE | DEGREE / ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|
| [illegible] | | 1/18/86 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| H. Amokrun M.D. | 319 So. Union Ave Havre MD 21078 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Removal/Cremation | Jan.20,1986 | R.A. Ferris and Co. | West Chester,Chester,PEna. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Tarring Funeral Home,P.A,Aberdeen,MD,21001-3399 | JAN 28 1986 | [illegible] |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

023090

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 02050

REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Tillie MIDDLE (nmn) LAST Breymaier | | 2a. DATE OF DEATH MONTH 1 DAY 17 YEAR 86 | 2b. HOUR 12:25 a.m. |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH 04 DAY 01 YEAR 02 | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) France Europe | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. |
| 10. CITY OR TOWN OF DEATH Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hosp. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY -- |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md | 13b. COUNTY Balto | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS / ZIP CODE 8129 Glen Gary Road, Balto. Md. 21234 |
| 14. FATHER'S NAME FIRST Unknown MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | (IF YES, GIVE WAR OR DATES) -- | 16b. SOCIAL SECURITY NO. 215-74-0871 | 17. INFORMANT Helen Kurrle, daughter — ADDRESS 8129 Glen Gary Road Baltimore, Md. 21234 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Malnutrition

DUE TO, OR AS A CONSEQUENCE OF (c) CVA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/23, 1985 to 1/16, 1986, that (I) (we) last saw the deceased alive on 1/16, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | DEGREE MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED 1/17/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. S. NAIR MD | | 22e. ADDRESS 2112 Belair Road Fallston | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Jan. 20, 1986 | 23c. NAME OF CEMETERY OR CREMATORY Whatcoat Meth. Cemetery, Snow Hill | 23d. LOCATION CITY OR TOWN / COUNTY Worcester / STATE Md. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS Howard K. MCComas III, Abingdon, Md. 21009 | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 | 25b. REGISTRAR'S SIGNATURE |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

028014

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 02051

REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Charles Frederick Brown | | 2a. DATE OF DEATH MONTH DAY YEAR: January 17, 1986 | 2b. HOUR: M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Aug. 8, 1902 | 6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. |
| 10. CITY OR TOWN OF DEATH: Aberdeen | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 120 Gunnison Drive | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Administrator | 12b. KIND OF BUSINESS OR INDUSTRY: US Gov't. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Harford | Aberdeen | YES ☒ NO ☐ | 120 Gunnison Drive/21001 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | | |
|---|---|---|---|
| Frederick Sprague Brown | Mary Ellen Kelly | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES): N/A | 16b. SOCIAL SECURITY NO.: 216-01-3052 | 17. INFORMANT ADDRESS: Florence E. Brown, Same as Above |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Advanced Carcinoma of Esophagus — Couple of months

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): cachexia

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): Not Applicable

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1983 19 to 1/17 1986, that (I) (we) last saw the deceased alive on 1/17 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: Jan. 20, 1986

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MANUEL M. LAZATIN, MD

22e. ADDRESS: 8 LAW ST. ABERDEEN MD. 21001

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Jan. 20, 1986 | Parkwood Cemetery | Baltimore City, Maryland |

24. FUNERAL DIRECTOR NAME / ADDRESS: Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3899

25a. DATE REC'D. BY REGISTRAR: JAN 24 1986

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

035030

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86 02052
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: HARRY — MIDDLE: — LAST: Buchanan

2a. DATE OF DEATH — KNOWN ☐ ESTIMATED ☑ — MONTH 1 DAY 29 YEAR 1986

2b. HOUR 1 a.m.

3. SEX: M

4. RACE: B

5. DATE OF BIRTH — MONTH 11 DAY 4 YEAR 19

6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS.

IF UNDER 1 YR. — MONTHS: — DAYS:

IF UNDER 24 HRS. — HOURS: — MIN.:

2c. DATE PRONOUNCED DEAD — MONTH 1 DAY 29 YEAR 1986

2d. HOUR 6 a.m.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.

10. CITY OR TOWN OF DEATH: Aberdeen

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 747 Battle av

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): —

12b. KIND OF BUSINESS OR INDUSTRY: —

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: HARFORD

13c. CITY OR TOWN: Aberdeen

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 747 Battle av 21001

14. FATHER'S NAME — FIRST: Raymond — MIDDLE: — LAST: Buchanan

15. MOTHER'S MAIDEN NAME — FIRST: Aida — MIDDLE: — LAST: Buchanan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes

(IF YES, GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 218-05-4357

17. INFORMANT: Personal Papers — ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY Heart DISEASE

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 1-29-86

EXAMINER'S NAME (TYPE OR PRINT): LUIS E RENJEL ADDRESS: 464 Alliance ST Havre de Grace 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb.1,1986

23c. NAME OF CEMETERY OR CREMATORY: Mount Calvary Cemetery

23d. LOCATION — CITY OR TOWN — COUNTY — STATE: Aberdeen,Harford,Maryland

24. FUNERAL DIRECTOR — NAME — ADDRESS: Tarring Funeral Home,P.A.,Aberdeen,MD,21001-3399

25a. DATE REC'D. BY REGISTRAR: JAN 31 1986

25b. REGISTRAR'S SIGNATURE: Shirley Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP_____

DHMH - 17 (VR A15 ME (5))

029070

STATE OF MARYLAND 86 02053
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Swanea MIDDLE Marie LAST Burton
SWANEA M. Burton

2a. DATE OF DEATH: MONTH JAN DAY 23 YEAR 1986
2b. HOUR 10 30 P M

3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH June DAY 5 YEAR 1904
6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Athens, W.Va.
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hosp
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: ---

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Harford
13c. CITY OR TOWN: Bel Air
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 203 Ruffs Mill Rd. ZIP CODE: 21014

14. FATHER'S NAME: FIRST Esaw MIDDLE -- LAST Akers
15. MOTHER'S MAIDEN NAME: FIRST Nancy MIDDLE -- LAST Clemons

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no
(IF YES, GIVE WAR OR DATES): ---
16b. SOCIAL SECURITY NO.: 216-24-3423
17. INFORMANT: Bryce E. Burton, ADDRESS: 2108 Thomas Run Road, Bel Air, Md. 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC
DUE TO, OR AS A CONSEQUENCE OF (c) HEART DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Renal Failure

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-10 19 86, to 1-23 19 86, that (I) (we) last saw the deceased alive on 1-10 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Dante Monakil MD
DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 1/25/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DANTE MONAKIL
22e. ADDRESS: Havre de Grace Md 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Jan.27,1986
23c. NAME OF CEMETERY OR CREMATORY: BelAir Memorial Gardens
23d. LOCATION: CITY OR TOWN Bel Air COUNTY Harford STATE Md.

24. FUNERAL DIRECTOR: NAME Howard K. MCComas III, ADDRESS Abingdon, Md. 21009
25a. DATE REC'D BY REGISTRAR: JAN 27 1986
25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

013069

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 02054

1. DECEASED NAME (TYPE OR PRINT): FIRST Sarah MIDDLE Ann LAST Lagan Cain

2a. DATE OF DEATH: MONTH 1 DAY 5 YEAR 86

2b. HOUR 10 40 A.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH May DAY 16 YEAR 1895

6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Harford

13c. CITY OR TOWN: Aberdeen

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 840 Lynn Lee Dr. / 21001

14. FATHER'S NAME: FIRST Andrew MIDDLE — LAST Lagan

15. MOTHER'S MAIDEN NAME: FIRST Sarah MIDDLE Ann LAST Terry

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 212-40-5791

17. INFORMANT: John P. Cain, Jr. ADDRESS: Same As Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

887

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a): Cardiorespiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Cardiogenic Shock 2° to Acute Anterolateral wall Myocardial Infarction — couple of days

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Ex Hip

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2): N/A

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/5, 1983, to 1/5, 1986, that (I) (we) last saw the deceased alive on 1/5, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M Mayer MD

DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/5/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LAZATIN, MANUEL

22e. ADDRESS: PO Box 579 8 Law St Aberdeen, MD 21001

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Jan. 9, 1986

23c. NAME OF CEMETERY OR CREMATORY: St. Ignatius Cem.

23d. LOCATION: CITY OR TOWN Hickory COUNTY Harford STATE MD

24. FUNERAL DIRECTOR: NAME Tarling Funeral Home, P.A. ADDRESS Aberdeen, MD. 21001-3399

25a. DATE REC'D BY REGISTRAR: JAN 9 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

009184

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 02055

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Daniel MIDDLE: D LAST: Calderbank | | 2a. DATE OF DEATH MONTH DAY YEAR: January 4, 1986 | 2b. HOUR: 2 A.M. |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: OCTOBER 22, 1899 | 6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Mem. Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): (RET) BUSINESS AGENT | 12b. KIND OF BUSINESS OR INDUSTRY: BARTENDERS UNION |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | |
| 13a. STATE: PA | 13b. COUNTY: | 13c. CITY OR TOWN: PHILADELPHIA | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 4249 'O' Street 19124 99999 |
| 14. FATHER'S NAME FIRST: ? MIDDLE: LAST: CALDERBANK | | 15. MOTHER'S MAIDEN NAME FIRST: MARY MIDDLE: LAST: HOFF | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES — (IF YES, GIVE WAR OR DATES): WW I | 16b. SOCIAL SECURITY NO.: 164 10 9187 | 17. INFORMANT: FRANCIS CALDERBANK, 35 BONNIE AVE, BEL AIR, MD. 21014 | ADDRESS |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Digital gangrene

DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12-24, 19 85, to 1-4, 19 86, that (I) (we) last saw the deceased alive on 1-4, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 1/4/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): L. FREILICH — 22e. ADDRESS: 1604 Churchville Road

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 8JANUARY86 | 23c. NAME OF CEMETERY OR CREMATORY: HOLY SEPULCHRE CEMETERY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: WINDMOORE TOWNSHIP, MONTGOMERY CO, PA. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: GUCKIN FUNERAL HOME, PHILADELPHIA, PA 19124 MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078 | | 25a. DATE REC'D BY REGISTRAR: JAN 2 1986 | 25b. REGISTRAR'S SIGNATURE |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon-paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate not signed.

BP ____

DHMH - 16 60M 7/84 (VRA 15, 4)

031044

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BAMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 2 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked "Yes" to any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 86 002056

1. DECEASED NAME (TYPE OR PRINT): FIRST Hazel MIDDLE Adelia LAST (Cochran) Cochran

2a. DATE OF DEATH (JAN. 21, 1986) MONTH DAY YEAR 1-21-86

2b. HOUR 2:30 P.M.

3. SEX: Female

4. RACE (White) CAUCASIAN

5. DATE OF BIRTH: MONTH 09 DAY 20 YEAR 1910

6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.

10. CITY OR TOWN OF DEATH: Fallston

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired - Teacher

12b. KIND OF BUSINESS OR INDUSTRY: N/A Public School

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Harford

13c. CITY OR TOWN: Bel Air

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 508 Rockspring Ave. 21014

14. FATHER'S NAME: FIRST Marshall MIDDLE Stuart LAST ORR

15. MOTHER'S MAIDEN NAME: FIRST Mamie MIDDLE Louella LAST Dick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO UNKNOWN

(IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 220-80-6177

17. INFORMANT (Name) Mrs. Charlene H. Gore CHART 692-5932 ADDRESS 3859 Federal Hill Rd. Jarrettsville, Maryland 21084

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Carcinoma of Colon to Liver — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/13, 19 86, to 1/21, 19 86, that (I) (we) last saw the deceased alive on 1/21, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Willard P. Amoss

DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/21/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Willard P. Amoss

22e. ADDRESS: 2030 Belair Rd, Fallston, MD 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: JAN. 24, 1986

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

23d. LOCATION: CITY OR TOWN Bel Air COUNTY Harford Co. STATE Maryland 21014

24. FUNERAL DIRECTOR: Joseph William Foster ADDRESS 50 W. Broadway & Williams St, Bel Air, Maryland 21014

25a. DATE REC'D. BY REGISTRAR: JAN 27 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

0 12

1 - FOR STATE REGISTRAR

STATE OF MARYLAND 86 02057
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Horace MIDDLE E LAST Cromwell | | 2a. DATE OF DEATH MONTH DAY YEAR January 6, 1986 | 2b. HOUR 12:58 P.M. |
| 3. SEX Male | 4. RACE Negro | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 25 1914 | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS; IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD. |
| 10. CITY OR TOWN OF DEATH Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher | 12b. KIND OF BUSINESS OR INDUSTRY Bd of ED. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE Md. | 13b. COUNTY HARFORD | 13c. CITY OR TOWN Havre de Grace | 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ | 13e. STREET ADDRESS / ZIP CODE 554 Alliance ST. 21078 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST Abel MIDDLE LAST Cromwell | | 15. MOTHER'S MAIDEN NAME FIRST MARTHA MIDDLE — LAST UNK. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | (IF YES, GIVE WAR OR DATES) WWII | 16b. SOCIAL SECURITY NO. 219-05-4532 | 17. INFORMANT Frances Cromwell, ADDRESS Havre de Grace Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic heart disease

DUE TO, OR AS A CONSEQUENCE OF (c) hypoxic encephalopathy & pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE Brian T. Jo | DEGREE M.D. | ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED 1/6/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Jan. 11-86 | 23c. NAME OF CEMETERY OR CREMATORY St. James Cemetery | 23d. LOCATION CITY OR TOWN Havre de Grace COUNTY Harford STATE Md. |
| 24. FUNERAL DIRECTOR NAME Otelia J. Bullock ADDRESS Havre de Grace Md. 21078 | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1986 | 25b. REGISTRAR'S SIGNATURE |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

010113

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 86 02058

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: ETHEL MAY CULYER | | 2a. DATE OF DEATH MONTH DAY YEAR: January 6, 1986 | 2b. HOUR: 2:45 P.M. |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Dec. 17, 1919 | 6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. |
| 10. CITY OR TOWN OF DEATH: Darlington | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3722 Love Road | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Seamtress | 12b. KIND OF BUSINESS OR INDUSTRY: Sewing Factory |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md. | Harford | Darlington | YES [ ] NO [X] | 3722 Love Rd. 21034 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST / MIDDLE / LAST: Ira Knauff | | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Catherine Cramer | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES): None | 220-07-1100 | 17. INFORMANT: Mr. Frank Culyer Husband Same as # 13 — ADDRESS |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOPULMONARY

DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CARCINOMA — 2mm

DUE TO, OR AS A CONSEQUENCE OF (c) BRAIN METS — 2mm

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEMS 18, PART 1 OR PART 2) 1/6/86

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/14/85 19 86 to 19 that (I) (we) last saw the deceased alive on 19 85 and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above. (I saw) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED 1/7/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN P. EDWARDS — 22e. ADDRESS 202 BEL AIR RD HALTON MD 21047

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: 1/7/1986 | 23c. NAME OF CEMETERY OR CREMATORY: Green Mount Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Baltimore Md. |

24. FUNERAL DIRECTOR NAME: E. Barnes — ADDRESS: Fleming Funeral Service - Benson, Md.

25a. DATE REC'D. BY REGISTRAR: JAN 8 1986 — 25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH-16 25M (VRA 15, 4) 1/79

009182

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 02059
REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: WILFRED MIDDLE: HERMAN LAST: DELBRIDGE | | 2a. DATE OF DEATH MONTH DAY YEAR: January 4, 1986 | 2b. HOUR: 7:25 PM |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Nov. 7, 1913 | 6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS. IF UNDER 1 YEAR: MONTHS DAYS. IF UNDER 24 HRS.: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Gasburg, Va. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. |
| 10. CITY OR TOWN OF DEATH: Abingdon | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 4624 Philadelphia Road | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Salesman | 12b. KIND OF BUSINESS OR INDUSTRY: Retail store |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE: Maryland | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Abingdon | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS / ZIP CODE: 4624 Philadelphia Road 21009 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST: Bernard MIDDLE: --- LAST: Delbridge | | 15. MOTHER'S MAIDEN NAME FIRST: Vallie MIDDLE: M. LAST: Clary | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no | (IF YES, GIVE WAR OR DATES): --- | 16b. SOCIAL SECURITY NO.: 216-05-5932 | 17. INFORMANT: Mrs. Margaret M. Delbridge, 4624 Philadelphia ADDRESS: Road, Abingdon, Md. 21009 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | METASTATIC CANCER OF THE PHARYNX | 18 Months |
| DUE TO, OR AS A CONSEQUENCE OF (b) | LOCAL DISEASE, METASTASIS TO LUNG | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CHRONIC OBSTRUCTIVE PULMONARY DISEASE

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [✓] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from NOV, 19 84, to JAN, 19 86, that ~~I~~ (we) last saw the deceased alive on @ NOV, 19 85, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: John N Saunders | DEGREE: MD | ATTENDING PHYSICIAN [✓] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: 1-5-86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN R. SAUNDERS | | 22e. ADDRESS: 1001 Cromwell Bridge Rd, Balt Md 21204 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Jan. 7, 1986 | 23c. NAME OF CEMETERY OR CREMATORY: Trinity Lutheran Cemetery, | 23d. LOCATION CITY OR TOWN: Joppa | COUNTY: Harford STATE: Md. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Howard K. McComas III, Abingdon, Md. 21009 | | 25a. DATE REC'D BY REGISTRAR: JAN 7 1986 | 25b. REGISTRAR'S SIGNATURE: | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

A

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

028010

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 86 02060

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: HARRY J. DeMULL | | 2a. DATE OF DEATH MONTH DAY YEAR: JANUARY 21, 1986 | 2b. HOUR: 1:30 P.M |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: JULY 23, 1912 | 6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS; IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: HARFDRD CDUNTY MD. |
| 10. CITY OR TOWN OF DEATH: HAVRE de GRACE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 135 WILSDN STREET | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): (RET) TEST TECH. | 12b. KIND OF BUSINESS OR INDUSTRY: FEDERAL GDVT. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE: MD | 13b. COUNTY: HARFDRD | 13c. CITY OR TOWN: HAVRE de GRACE | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 135 WILSDN STREET 21D78 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST / MIDDLE / LAST: HARRY DeMULL | | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: HATTIE WALKER | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): ND | (IF YES, GIVE WAR OR DATES): | 16b. SOCIAL SECURITY NO.: 22D 2D 7847 | 17. INFORMANT ADDRESS: MRS. NANCY BRATCHER 801 LAFAYETTE ST. HdG, MD. 21078 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Infarct

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 86, to 1.21, 19 86, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: [signature] | DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 1.21.86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): GUNTHER HIRSCH, M.D. | 22e. ADDRESS: 131 SDUTH UNIDN AVE. HAVRE de GRACE, MD. | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 23JANUARY86 | 23c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL CEMETERY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: HAVRE de GRACE, HARFORD CO., MD. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: MITCHELL FUNERAL HDME PA, HAVRE de GRACE, MD. 21D78 | | 25a. DATE REC'D BY REGISTRAR: JAN 23 1986 | 25b. REGISTRAR'S SIGNATURE |

017063

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 02061
REG. NO

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Minnie MIDDLE V. LAST Dick | | 2a. DATE OF DEATH MONTH DAY YEAR January 7 1986 | 2b. HOUR 4:00 a.m. |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Nov 10 1892 | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. |
| 10. CITY OR TOWN OF DEATH Cardiff | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1580 Main St. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE Md. | 13b. COUNTY Harford | 13c. CITY OR TOWN Cardiff | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS / ZIP CODE 1580 Main St., Cardiff, Md 21024 |

| | | |
|---|---|---|
| 14. FATHER'S NAME FIRST Nelson MIDDLE LAST Allen | 15. MOTHER'S MAIDEN NAME FIRST Retta MIDDLE S. LAST Jarvis | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. 213-38-5817 | 17. INFORMANT ADDRESS Irene Dick, 1580 Main St, Cardiff, Md |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) pneumonia —

DUE TO, OR AS A CONSEQUENCE OF (b) obstructive lung disease, chronic

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): malnutrition, right hemiplegia

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE Herbert Martello DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | | 22c. DATE SIGNED 01/07/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herbert A. Martello, MD | 22e. ADDRESS Whiteford, Maryland | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Jan. 10, 1986 | 23c. NAME OF CEMETERY OR CREMATORY Highland | 23d. LOCATION CITY OR TOWN Street COUNTY Harford STATE Md. |
| 24. FUNERAL DIRECTOR NAME John H. Harkins ADDRESS 600 Main St., Delta, Pa., 17314 | | 25a. DATE REC'D. BY REGISTRAR JAN 10 1986 | 25b. REGISTRAR'S SIGNATURE Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

035033

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 02062

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (FIRST, MIDDLE, LAST) NORMAN BENNETT DILL | | 2a. DATE OF DEATH (MONTH, DAY, YEAR) January 20 1986 | 2b. HOUR 11A M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH (MONTH, DAY, YEAR) 1 21 06 | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rocks, Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. |
| 10. CITY OR TOWN OF DEATH Bel Air | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 761 Henderson Road | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | 12b. KIND OF BUSINESS OR INDUSTRY Agriculture |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Harford | Bel Air | YES ☐ NO ☒ | 761 Henderson Road 21014 |

| 14. FATHER'S NAME (FIRST, MIDDLE, LAST) | 15. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST) |
|---|---|
| Andrew Jackson Dill | Mary Margaret Badders |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | --- | 218-38-4999 | Jackson B. Dill,Sr., | 771 Henderson Road, Bel Air,Md. 21014 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO-RESP. FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS

DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED A.S.C.V.D — 2 YEARS

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) —

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| — | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY (HOUR A.M. P.M., MONTH, DAY, YEAR 19) | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION (STREET, CITY OR TOWN, COUNTY, STATE) |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 5 OCT 19 84 to 28 JAN 19 86, that (I) (we) last saw the deceased alive on 28 JAN 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE — DEGREE | ATTENDING PHYSICIAN | MEDICAL DIRECTOR | STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|---|---|
| Harvey P. Sidwell M.D. | ☐ | ✓ | ☐ | 1-30-86 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Harvey P. Sidwell, M.D. | 401 Franklin Street, Bel Air,Md. 21014 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE) |
|---|---|---|---|
| Burial | Feb.3,1986 | BelAir Memorial Gardens | Bel Air Harford Md. |

| 24. FUNERAL DIRECTOR (NAME, ADDRESS) | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Howard K. McComas III, Abingdon,Md. 21009 | JAN 31 1986 | Sylvia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 of 72 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

020124

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 02063

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Paul MIDDLE: L. LAST: DiPeso | | 2a. DATE OF DEATH (MONTH DAY YEAR): 1/13/86 | 2b. HOUR: 2:45 P.M. |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH (MONTH DAY YEAR): 8 31 1932 | 6. AGE (IN YEARS LAST BIRTHDAY): 53 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford Co. MD. |
| 10. CITY OR TOWN OF DEATH: Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Self Employed | 12b. KIND OF BUSINESS OR INDUSTRY: Tavern Owner |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Harford | Fallston | YES ☐ NO ☐ | 2411 Friendship Road 21047 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Louis | | DiPeso | Florence | | Umidi |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | Korea | 147-24-6025 | Josephine A. DiPeso | Same as 13e |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiac arrest | 2 min |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Septic shock | hrs (?) |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Bronchopneumonia | 2-3d (?) |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Multiple Myeloma X 7 yrs still on chemotherapy

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from Jan. 13, 19 86, to Jan 13, 19 86, that (I) (we) last saw the deceased alive on Jan 13, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Albert S. C. Sun MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 1/14/86 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Albert S. C. Sun, MD. | 1800 Harford Rd. Fallston 21047 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 1/17/1986 | Sacred Heart Of Jesus | Dundalk | Baltimore | Maryland |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Duda-Ruck, Inc. | 7922 Wise Avenue Dundalk, Maryland 21222 | JAN 16 1986 | Gina Davidson-Kondale |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

020277

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

FOR 1 - STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 86 0206 4

1. DECEASED NAME (TYPE OR PRINT): FIRST Victoria 2. MIDDLE (DORA) LAST DOROBA

2a. DATE OF DEATH: MONTH 1 DAY 14 YEAR 86

2b. HOUR: 12:45 P.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH Aug. DAY 2, YEAR 1898

6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. IF UNDER 1 YEAR: MONTHS ___ DAYS ___ IF UNDER 24 HRS: HOURS ___ MIN. ___

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.

10. CITY OR TOWN OF DEATH: HAVRE de GRACE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): CITIZENS NURSING HOME

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Linen work

12b. KIND OF BUSINESS OR INDUSTRY: distillery

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: ✓

13c. CITY OR TOWN: Balto..

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 2323 Fleet Street 21231

14. FATHER'S NAME: FIRST Vincent MIDDLE LAST Wichert

15. MOTHER'S MAIDEN NAME: FIRST Frances MIDDLE LAST Budzynska

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 219-18-6203

17. INFORMANT: Frances Lelonek ADDRESS: 4026 Elmore Ave. 21213

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Massive hemoptysis

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John D. Yun DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/14/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): John D. Yun

22e. ADDRESS: Havre de grace, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1-17-86

23c. NAME OF CEMETERY OR CREMATORY: Holy Rosary

23d. LOCATION: CITY OR TOWN Balto. COUNTY STATE Md.

24. FUNERAL DIRECTOR: NAME John M. Weber & Sons Inc. ADDRESS 401 S. Chester St.

25a. DATE REC'D. BY REGISTRAR: JAN 16 1986

25b. REGISTRAR'S SIGNATURE

024015

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 002065

REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Everett MIDDLE: Linwood LAST: Dunn | | 2a. DATE OF DEATH MONTH DAY YEAR: January 14, 1986 | 2b. HOUR: 7:29 A.M. |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Sept. 5, 1936 | 6. AGE (IN YEARS LAST BIRTHDAY): 49 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): No. Carolina | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hosp | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Electrician | 12b. KIND OF BUSINESS OR INDUSTRY: Private |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE: Marylandd | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Darlington | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS / ZIP CODE: 2517 Shuresville RD Apt. 2-A 21034 |
| 14. FATHER'S NAME FIRST: William MIDDLE: Everett LAST: Dunn | | | 15. MOTHER'S MAIDEN NAME FIRST: Thelma MIDDLE: Lee LAST: Self | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES): N/A | 16b. SOCIAL SECURITY NO.: 248-50-5496 | 17. INFORMANT ADDRESS: Geneva V. Dunn, Same as Aboye | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b) diabetic ketoacidosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 1/16/85, 19__, to 1/14, 1986, that (I) (we) last saw the deceased alive on __, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) did) did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 1/18/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LINDA Freich — 22e. ADDRESS: 1604 Churchville Road

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Jan. 16, 1986 | 23c. NAME OF CEMETERY OR CREMATORY: Angel Hill Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Havre de Grace, Harford, MD |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Tarring Funeral Home, PA, Aberdeen, MD, 21001-3399 | | 25a. DATE REC'D. BY REGISTRAR: JAN 22 1986 | 25b. REGISTRAR'S SIGNATURE |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2[illegible] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely f[illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be [illegible] within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83 (VRA 15, 4)

013057

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

86 02066

REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Wesley MIDDLE James LAST Duty | | 2a. DATE OF DEATH MONTH DAY YEAR 1/8/86 | 2b. HOUR 7:56 M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR June 29, 1912 | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Buchanan, Va. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. |
| 10. CITY OR TOWN OF DEATH Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman | 12b. KIND OF BUSINESS OR INDUSTRY Highway Dept. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Harford | Joppa | YES [ ] NO [X] | 2211 Mountain Road 21085 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST Creed MIDDLE — LAST Duty | | 15. MOTHER'S MAIDEN NAME FIRST Louise MIDDLE -- LAST McFadden | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | (IF YES, GIVE WAR OR DATES) -- | 16b. SOCIAL SECURITY NO. 236-18-3892 | 17. INFORMANT Mrs.Vivian A.Duty, ADDRESS 2211 Mountain Road,Joppa, Md. 21085 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Severe CHD

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Block leg = COPD

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____ 19 86, to _____ 19 86, that (I) (we) last saw the deceased alive on Jan 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE [signature] | DEGREE M.D. ATTENDING PHYSICIAN [✓] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NATR V | 22e. ADDRESS 2112 Bel Air Road - Fallston | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Jan.10,1986 | 23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens | 23d. LOCATION CITY OR TOWN Bel Air COUNTY Harford STATE Md. |
| 24. FUNERAL DIRECTOR NAME Howard K. McComas III, ADDRESS Abingdon,Md. 21009 | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1986 | 25b. REGISTRAR'S SIGNATURE |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

023045

86 02067

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: CARRIE MIDDLE: CURRIER LAST: EATON | | 2a. DATE OF DEATH MONTH DAY YEAR: JAN. 17, 1986 | 2b. HOUR: 1:02 PM |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: NOVEMBER 25, 1887 | 6. AGE (IN YEARS LAST BIRTHDAY): 98 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER | 12b. KIND OF BUSINESS OR INDUSTRY: |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD | HARFORD | HAVREde GRACE | YES ☒ NO ☐ | 620 OTSEGO STREET 21078 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| OLIVER | R. | CURRIER | EMMA | JANE | CRAWFORD |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 220 44 3033 | OLIVER M. CURRIER | 800 SOUTH MARKET STREET, HdG, MD. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bilateral Pneumonia

DUE TO, OR AS A CONSEQUENCE OF (b) intestinal obstruction

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 1/12 1986 to 1/17 1986, that (I) (we) last saw the deceased alive on 1/17 1986, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| John Yun | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 1/17/86 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| JOHN D YUN | Havre de Grace, Md |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 19JANUARY86 | ANGEL HILL CEMETERY | HAVRE de GRACE, HARFORD CO., MD. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| MITCHELL FUNERAL HOME PA | HAVRE de GRACE, MD. 21078 | JAN 21 1986 | [signature] |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

017101

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 02068

1. DECEASED NAME (TYPE OR PRINT) FIRST: Beatrice MIDDLE: J. LAST: Gant

2a. DATE OF DEATH MONTH: Jan DAY: 8 YEAR: 1986

2b. HOUR: 9 P M

3. SEX: Female

4. RACE: Black

5. DATE OF BIRTH MONTH: May DAY: 7 YEAR: 1922

6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ark

7b. CITIZEN OF WHAT COUNTRY?: U.S.A

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Nurses Aid

12b. KIND OF BUSINESS OR INDUSTRY: Hospital

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Harford

13c. CITY OR TOWN: Aberdeen

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 202 Teale Lane 21001

14. FATHER'S NAME FIRST: Ben MIDDLE: LAST: Johnson

15. MOTHER'S MAIDEN NAME FIRST: Catherine MIDDLE: LAST: Mills

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): —

16b. SOCIAL SECURITY NO.: 458-38-4872

17. INFORMANT: Kenneth Gant ADDRESS: Edgewood, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypotension CHF. ASVD

DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus

DUE TO, OR AS A CONSEQUENCE OF (c) Metabolic acidosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: —

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-7, 19 86, to 1-8, 19 86, that (I) (we) last saw the deceased alive on 1-8, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. T. Lee DEGREE: M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/10/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. T. Lee

22e. ADDRESS: Union Med. Clinic, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Jan. 13-86

23c. NAME OF CEMETERY OR CREMATORY: Belair Memorial Gd.

23d. LOCATION CITY OR TOWN: Bel Air COUNTY: Harford STATE: Md.

24. FUNERAL DIRECTOR: Otelia J. Bullock ADDRESS: Havre de Grace Md.

25a. DATE REC'D BY REGISTRAR: JAN 14 1986

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

010114

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 02069
REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: Harriett S. Golumbic | | 2a. DATE OF DEATH MONTH DAY YEAR: January 7, 1986 | 2b. HOUR: 8:05 p.m. |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: July 24, 1907 | 6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Conn. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. |
| 10. CITY OR TOWN OF DEATH: Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): (Retired) Self-Employed | 12b. KIND OF BUSINESS OR INDUSTRY: State Venetion Blin Co. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE: Conn. | 13b. COUNTY: New London | 13c. CITY OR TOWN: New London | 13d. INSIDE CITY LIMITS? YES XX NO ☐ | 13e. STREET ADDRESS: 1027 Ocean Avenue 06320 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST MIDDLE LAST: Harris Salowitz | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Celia Weinstein | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | 16a. (IF YES, GIVE WAR OR DATES): None | 16b. SOCIAL SECURITY NO: 042-07-8903 | 17. INFORMANT: (daughter) ADDRESS: 206 E. Mac Phail Rd. Mrs. Cynthia Suntup Bel Air, Md. 21014 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE (a)) Cardiac Arrest. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration Pneumonia. — 12 Hours.
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Metastatic cancer of colon ; Cerebro Vascular Accident

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: — | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: — | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from DECEMBER, 19 85, to 1/7, 19 86, that (I) (we) last saw the deceased alive on 1/7, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: [signature] | DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 1/7/86. |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): FRANZ C. VELLA-CAMILLERI | 22e. ADDRESS: 827 LINDEN AVE BALTO MD 21201 | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Jan. 9, 1986 | 23c. NAME OF CEMETERY OR CREMATORY: Beth El Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE: Groton New London Conn. |
| 24. FUNERAL DIRECTOR NAME: E. Barnes ADDRESS: 21018 Fleming Funeral Service Benson, Md. | | 25a. DATE REC'D. BY REGISTRAR: JAN 8 1986 | 25b. REGISTRAR'S SIGNATURE: [signature] |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

999999

DHMH-16 25M
(VRA 15, 4) 1/79

014104

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 02070

REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Edward MIDDLE P LAST Hawkes | | 2a. DATE OF DEATH MONTH DAY YEAR January 7, 1986 | 2b. HOUR 8:20 A.M. |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 10, 1913 | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD. |
| 10. CITY OR TOWN OF DEATH Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Diesel Mech. | 12b. KIND OF BUSINESS OR INDUSTRY Ind. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Md. | Cecil | North East | YES [ ] NO [X] | 314 Lakeside Dr. 21901 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST Edward MIDDLE P. LAST Hawkes | | 15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Cotter LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. 578-03-7546 | 17. INFORMANT Edward P. Hawkes Jr. ADDRESS 4212 Hoffman Dr. Dale City, Va. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac failure

DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD. CAD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE T. T. Lee | DEGREE M.D. | ATTENDING PHYSICIAN [✓] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED 1/7/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. T. Lee | | 22e. ADDRESS | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1-9-86 | 23c. NAME OF CEMETERY OR CREMATORY Ceder Hill Cem. | 23d. LOCATION CITY OR TOWN Suitland COUNTY Princes Georges STATE Md. |
| 24. FUNERAL DIRECTOR NAME Robert T Crouch | ADDRESS Crouch Funeral Home North EAst, Md | 25a. DATE REC'D. BY REGISTRAR JAN 10 1986 | 25b. REGISTRAR'S SIGNATURE |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

013068

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 02071

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Jeanie MIDDLE F LAST Hipple | | 2a. DATE OF DEATH MONTH DAY YEAR January 1, 1986 | 2b. HOUR 9:30 AM |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR JANUARY 30, 1893 | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS; IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. |
| 10. CITY OR TOWN OF DEATH Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | |
| 13a. STATE MD | 13b. COUNTY HARFORD | 13c. CITY OR TOWN HAVRE de GRACE | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ |
| 13e. STREET ADDRESS / ZIP CODE 319 LAFAYETTE STREET 21078 | | | |
| 14. FATHER'S NAME FIRST HARRY MIDDLE O'NEIL LAST MOORE | | 15. MOTHER'S MAIDEN NAME FIRST EVALEEN MIDDLE LAST ALE | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO 218 03 8962 D | 17. INFORMANT ADDRESS MRS. HOPE (FORWOOD) HIPPLE 813 S. ADAMS ST HdG, MD 21078 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio-pulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD & COPD

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 888

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Fractured (L) hip

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION 12/31/85 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fx (L) hip | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☒ (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 12 30 85 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Slipped & fell in own kitchen | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home | 21f. LOCATION STREET Home CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/30/85 19__ to 1/1/86 that (I) (we) last saw the deceased alive on 1/1/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE Charles J. Foley | DEGREE MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. FOLEY JR | | 22e. ADDRESS HAVRE de GRACE Md. | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 5 JANUARY 86 | 23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY | 23d. LOCATION CITY OR TOWN HAVRE de GRACE, COUNTY HARFORD CO., STATE MD. |
| 24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, ADDRESS HAVRE de GRACE, MD. 21078 | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1986 | 25b. REGISTRAR'S SIGNATURE [illegible] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the state.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

013043

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 02072

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: Mary K. Hofsommer

2a. DATE OF DEATH MONTH DAY YEAR: January 7, 1986

2b. HOUR: M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: Aug. 31 1925

6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.

10. CITY OR TOWN OF DEATH: Forrest Hill

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 2286 Phillips Mill Rd.

12a. USUAL OCCUPATION (GIVE KIND OF WORK DURING MOST OF WORKING LIFE): Waitress

12b. KIND OF BUSINESS OR INDUSTRY: Restaurant

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Baltimore

13c. CITY OR TOWN: Middle River

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 311 Dark Head Rd. 21220

14. FATHER'S NAME FIRST MIDDLE LAST: James O. Kellison

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Flora M. McGlothlin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): -

16b. SOCIAL SECURITY NO.: 214 24 2059

17. INFORMANT: Emerson R. Hofsomer, Jr. ADDRESS: ~~800 Lannerton Rd.~~ Balto., Md. 21220

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Lung Carcinoma

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: S Milner

DEGREE: MD

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/9/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MILNER

22e. ADDRESS: 404 Eastern Blvd

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1/10/86

23c. NAME OF CEMETERY OR CREMATORY: Holly Hill Memorial Gardens

23d. LOCATION CITY OR TOWN COUNTY STATE: Baltimore Co., Md.

24. FUNERAL DIRECTOR: Bruzzinski Funeral Home PA 1407 Old Eastern Ave

25a. DATE REC'D BY REGISTRAR: JAN 9 1986

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or medically filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

009193

1 - FOR STATE REGISTRAR

STATE OF MARYLAND 86 02073
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Robert MIDDLE Herman LAST Holdaway | | 2a. DATE OF DEATH MONTH DAY YEAR January 1, 1986 | 2b. HOUR 8a A M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Feb.15, 1908 | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. |
| 10. CITY OR TOWN OF DEATH Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | 13b. COUNTY Harford | 13c. CITY OR TOWN Darlington | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] 13e. STREET ADDRESS / ZIP CODE 1831 Deth's Ford RD/ 21034 |
| 14. FATHER'S NAME FIRST Ellis MIDDLE LAST Holdaway | | 15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE LAST Holdaway | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | (IF YES, GIVE WAR OR DATES) N/A | 16b. SOCIAL SECURITY NO. 220-30-0927 | 17. INFORMANT Mary R. Holdaway, 1831 Deth's Ford Rd. ADDRESS Darligton, MD 21034 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest — ASCVD

DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Ca from Colon

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/31/ 19 85 to 1/1 19 86, that (I) (we) last saw the deceased alive on / / 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE Dante M. Monakil | DEGREE ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED 1/1/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE M. MONAKIL | 22e. ADDRESS Havre de Grace, Md 21078 | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Jan.6,1986 | 23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gdns. | 23d. LOCATION CITY OR TOWN Bel Air COUNTY Harford, Maryland |
| 24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A, ADDRESS Aberdeen, MD, 21001-3399 | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1986 | 25b. REGISTRAR'S SIGNATURE Julia Davidson |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

017073

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 02074

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary MIDDLE: R LAST: Hutton | | 2a. DATE OF DEATH MONTH DAY YEAR: Jan 7 1986 | 2b. HOUR: 4:44 P.M. |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: March 25 1928 | 6. AGE (IN YEARS LAST BIRTHDAY): 57 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Harford | Edgewood | YES [X] NO [ ] | 624 Longwood Court/21040 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST: Joseph MIDDLE: H. LAST: Sheeler | | 15. MOTHER'S MAIDEN NAME FIRST: Agnes MIDDLE: LAST: Wilson | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): ---------- | 16b. SOCIAL SECURITY NO.: 216-24-0962 | 17. INFORMANT: Charles H. Hutton 624 Longwood Court ADDRESS: Edgewood, MD |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute MI | 1.30 h |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Severe Coronary art. disease | 7 yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Long term Diabetes Mellitus with hypertension. | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Gangrene @ 2nd toe.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: 1.7.86. | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Gangrene @ 2nd toe & abdominal @ Septicemia | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 1.6.86 to 1.7.86, that (I) (we) last saw the deceased alive on 1.7.86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: M. J. | DEGREE: MD. ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: 1.7.86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): M. JISADA MD. | 22e. ADDRESS: 433 Snd St. Hdb MD. 21078 | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 1/10/86 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Nebo Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Peachbottom Twp. York, PA |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: John Harkins 600 Main Street Delta, PA 17314 | | 25a. DATE RECD. BY REGISTRAR: JAN 10 1986 | 25b. REGISTRAR'S SIGNATURE: Fern Lauritson Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other [illegible] the medical examiner must be [illegible]

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

021106

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

B 0 0 2 0 7 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: MARY — MIDDLE: Wajer — LAST: JANKIEWICZ

2a. DATE OF DEATH — KNOWN ☑ ESTIMATED ☐ — MONTH 1 DAY 14 YEAR 1986

2b. HOUR 7:30 P.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH 3 DAY 23 YEAR 01

6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD — MONTH 1 DAY 14 YEAR 1986

2d. HOUR 7:40 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland USA

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.

10. CITY OR TOWN OF DEATH: FALLSTON

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Home maker

12b. KIND OF BUSINESS OR INDUSTRY: ------

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY: HARFORD — 13c. CITY OR TOWN: BALDWIN — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 2913 Placid Rd Baldwin Md 21013

14. FATHER'S NAME — FIRST: Francis — MIDDLE: Wajer — LAST:

15. MOTHER'S MAIDEN NAME — FIRST: Josephine — MIDDLE: Szulczewski — LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): ----------

16b. SOCIAL SECURITY NO.: 219-07-0228

17. INFORMANT: Margaret Large — ADDRESS: 2913 Placid Dr Baldwin, Md 21013

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Luis E Renjel — M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 1-15-86

EXAMINER'S NAME (TYPE OR PRINT): LUIS E RENJEL — ADDRESS: 464 Allameer Hob Grove 21071

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 01/18/86 — 23c. NAME OF CEMETERY OR CREMATORY: St Stanislaus Cem — 23d. LOCATION CITY OR TOWN: Baltimore, Md — COUNTY — STATE

24. FUNERAL DIRECTOR — NAME: Dippel Funeral Homes Inc — ADDRESS: 7110 Belair Rd Baltimore Md 21206

25a. DATE REC'D. BY REGISTRAR: JAN 17 1986

25b. REGISTRAR'S SIGNATURE: Lina Davidson-Randell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP_____

DHMH - 17 (VR A15 ME (5)) 15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REGISTRAR — REG. NO. 86 002076

016037

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: GRACE KIELEK | | | 2a. DATE OF DEATH MONTH DAY YEAR: 1 8 86 | 2b. HOUR: 5:45 PM |
| 3. SEX: F | 4. RACE: CAUC. | 5. DATE OF BIRTH MONTH DAY YEAR: 3 18 24 | 6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MASS. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH: FALLSTON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GEN. HOSP | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER | 12b. KIND OF BUSINESS OR INDUSTRY: — |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND | 13b. COUNTY: — | 13c. CITY OR TOWN: BALTIMORE | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 1233 BROENING HWY 21224 |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST: HARRY HOWARTH | | | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: EHA | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES): — | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: KATHLEEN JAmitis | ADDRESS: Edgewood 21048 1901 HAREWOOD Cr |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE — 1 MO

DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY HYPERTENSION — > 24 YRS

DUE TO, OR AS A CONSEQUENCE OF (c) RHEUMATIC HEART DISEASE — > 40 YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PNEUMONIA

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11/20/ 19 85, to 1/9 19 86, that (I) (we) last saw the deceased alive on 1/9 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: [signature] | DEGREE: MD | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 1/5/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARILYN J MACVEY | | 22e. ADDRESS: FALLSTON GEN HOSPITAL | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 1/13/86 | 23c. NAME OF CEMETERY OR CREMATORY: Holy Rosary Cem. | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: BALTIMORE MD |
| 24. FUNERAL DIRECTOR NAME: KACZOROWSKI FUNERAL HOME | ADDRESS: 2525 Fleet St 21224 | 25a. DATE REC'D. BY REGISTRAR: JAN 13 1986 | 25b. REGISTRAR'S SIGNATURE: |

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

017001

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 02071

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: ELEANOR MIDDLE: CANNON LAST: KROH | | 2a. DATE OF DEATH MONTH DAY YEAR: January 13, 1986 | 2b. HOUR: 6:30 AM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: March 12, 1902 | 6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. |
| 10. CITY OR TOWN OF DEATH: Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 664 Green Street | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk | 12b. KIND OF BUSINESS OR INDUSTRY: US-govt. Ret. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE: Maryland | 13b. COUNTY: Balto. | 13c. CITY OR TOWN: Kingsville | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS / ZIP CODE: 12032 Belair Road 21087 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST: Milton MIDDLE: Harvey LAST: Cannon | | 15. MOTHER'S MAIDEN NAME FIRST: Margaurite MIDDLE: Lucinda LAST: Traugh | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no | (IF YES, GIVE WAR OR DATES): -- | 16b. SOCIAL SECURITY NO.: 220-20-7642 | 17. INFORMANT: Thomas B. Evans, 12032 Belair Road, Kingsville Md. 21087 ADDRESS |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE MYO CARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF (b) PSCVD

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from OCT 15, 19 84, to JAN 12, 19 86, that (I) (we) last saw the deceased alive on OCT 3, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: [signature] DEGREE: MD; ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | | 22c. DATE SIGNED: 1/13/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): M. M. MENENDEZ, MD | 22e. ADDRESS: 5820 YORK RD BALTO. MD 21212 | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: Jan. 13, 1986 | 23c. NAME OF CEMETERY OR CREMATORY: R.A.Ferris Crematory | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: W.Chester Chester Pa. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: Howard K. McComas III, Abingdon, Md. 21009 | | 25a. DATE REC'D BY REGISTRAR: JAN 14 1986 | 25b. REGISTRAR'S SIGNATURE: [signature] |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

036180

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 02078

REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Walter MIDDLE: Bryant LAST: Lassiter | | 2a. DATE OF DEATH MONTH DAY YEAR: January 29, 1986 | 2b. HOUR: M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: 11 14 1901 | 6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS — IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. |
| 10. CITY OR TOWN OF DEATH: Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 2104 Brookhaven Court | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Super Market Employee | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Baltimore | 13c. CITY OR TOWN: Dundalk | 13d. INSIDE CITY LIMITS? YES [ ] NO [X]; 13e. STREET ADDRESS / ZIP CODE: 1909 Kelmore Road 21222 |
| 14. FATHER'S NAME FIRST: Eugene LAST: Lassiter | | 15. MOTHER'S MAIDEN NAME FIRST: Elizabeth MIDDLE: LAST: Not Known | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes | (IF YES, GIVE WAR OR DATES): WW II | 16b. SOCIAL SECURITY NO.: 309-28-5541 | 17. INFORMANT: Mary M. Lassiter ADDRESS: 2104 Brookhaven Court Fallston, MD. 21047 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Carcinoma Lung (Metastatic)

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Dec, 19 85, to JAN, 19 86, that (I) (we) last saw the deceased alive on JAN 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 1/30/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MYO THAN — 22e. ADDRESS: 9101 FRANKLIN SQ. DR BALTO, MD 21237

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 2/1/1986 | 23c. NAME OF CEMETERY OR CREMATORY: Holly HIll | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: White Marsh Maryland |
| 24. FUNERAL DIRECTOR NAME: Duda-Ruck, INc. ADDRESS: 7922 Wise Avenue Dundalk, Maryland 21222 | | 25a. DATE REC'D. BY REGISTRAR: FEB 03 1986 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

023046

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 02079

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Grace MIDDLE Isabelle LAST Lewis<br>Grace I Lewis | | 2a. DATE OF DEATH MONTH 1 DAY 16 YEAR 86 | 2b. HOUR 9:30 p M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH July DAY 14, YEAR 1912 | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. / IF UNDER 1 YEAR MONTHS DAYS / IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Magnolia, Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. |
| 10. CITY OR TOWN OF DEATH Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY --- |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE Maryland | 13b. COUNTY Harford | 13c. CITY OR TOWN Magnolia | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS / ZIP CODE 105 Fort Hoyle Road 21101 |

| | | | | |
|---|---|---|---|---|
| 14. FATHER'S NAME FIRST William MIDDLE Frederick LAST Gunther | | | 15. MOTHER'S MAIDEN NAME FIRST Katherine MIDDLE Lucille LAST Carroll | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | (IF YES, GIVE WAR OR DATES) -- | 16b. SOCIAL SECURITY NO. 213-60-2481 | 17. INFORMANT Ruth C. Owen | ADDRESS 112 Melodic Drive, Newark, Del. 19713 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

IMMEDIATE CAUSE (a) Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9:30 pm

DUE TO, OR AS A CONSEQUENCE OF (b) Terminal Respiratory failure — 2-3 yrs

DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure with Cor pulmonale

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic asthma and pulmonary Emphysema Diabetes Mellitus

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Dec. 30, 19 85, to Jan. 16, 19 86, that (I) (we) last saw the deceased alive on Jan 16, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE Albert S. C. Sun, MD — DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ | | 22c. DATE SIGNED 1/17/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert S. C. Sun, M.D. | 22e. ADDRESS 1800 Harford Rd. Fallston, MD 21047 | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Jan. 20, 1986 | 23c. NAME OF CEMETERY OR CREMATORY BelAir Memorial Gardens | 23d. LOCATION CITY OR TOWN Bel Air COUNTY Harford STATE Md. |
| 24. FUNERAL DIRECTOR NAME Howard K. McComas III, ADDRESS Abingdon, Md. 21009 | | 25a. DATE REC'D. BY REGISTRAR JAN 21 1986 | 25b. REGISTRAR'S SIGNATURE Mary Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

013071

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 02080

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Samuel | | Lopez | January 3, 1986 | 8:25 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
|---|---|---|---|---|---|
| Male | White | Mar. 27, 1936 | 49 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARITAL STATUS | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Michigan | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | Harford County MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Havre de Grace | Harford Memorial Hosp. | Photographer | US Gov't. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Harford | Aberdeen | YES [X] NO [ ] | 65 Green Ave./21001 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Jose | Maria | Lopez | Soledad | Sanchez | Lopez |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| Yes | 58-61 | 374-30-1940 | Mildred Lopez, Same as Above |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiogenic shock | 30 hours |
| DUE TO, OR AS A CONSEQUENCE OF (b) | ant. lat wall MI. | 5 yrs. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [X] NO [ ] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from 1981, 19__, to 1-3, 1986, that (I) (we) last saw the deceased alive on 1-2, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 1-3-86. |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| B.D. PAREKH M.D. | 1908 HARFORD RD, PALLSTON MD 21047 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | Jan. 6, 1986 | Harford Mem. Gdns. | Aberdeen, Harford, Maryland |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Tarring Funeral Home, P.A. | Aberdeen, MD, 21001-3399 | JAN 9 1986 | [illegible] |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

020121

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 02081

REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Catherine MIDDLE Marie LAST Ludwigson

2a. DATE OF DEATH: MONTH DAY YEAR January 8, 1986

2b. HOUR: 8:50 P.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH DAY YEAR Nov. 26, 1913

6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Jasper Indiana

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County, MD.

10. CITY OR TOWN OF DEATH: Bel Air

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bel Air Nursing and Convalescent Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Director of Personel

12b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Harford Co.

13c. CITY OR TOWN: Bel Air

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 314-C Crocket Drive 21014

14. FATHER'S NAME: FIRST Eugene MIDDLE Aloysius LAST Strum

15. MOTHER'S MAIDEN NAME: FIRST ~~Mary~~ Maye MIDDLE Victoria LAST Said

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

16b. (IF YES, GIVE WAR OR DATES): —

SOCIAL SECURITY NO.: 310-03-5950

17. INFORMANT (Sister) 1-317-251-5713 ADDRESS: Mrs. Bernice S. Teer, 5714 North Rural Street, Indianapolis, Indiana 46220

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CACHEXIA

DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA LT BREAST WITH METASTASES TO SPINAL COLUMN AND PELVIS

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ ~~OR CONTRIBUTING~~ ☐ ~~CAUSE OF DEATH~~ (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from JAN 23, 1964 19____ to JAN 8 1986 that (I) (~~we~~) last saw the deceased alive on JAN 4 1986 and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Philip W. Heuman M.D. DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1-9-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Philip W. Heuman, M.D.

22e. ADDRESS: 307 Hickory Avenue, Bel Air, Maryland 21014

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: Jan. 9, 1986

23c. NAME OF CEMETERY OR CREMATORY: R.A. Ferris & Co. Crematory

23d. LOCATION: CITY OR TOWN West Chester, COUNTY Pennsylvania STATE 19380

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: 50 W. Broadway & Williams St. Bel Air, Maryland 21014

25a. DATE REC'D BY REGISTRAR: JAN 13 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson Rogers

007067

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86 02082
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Allen MIDDLE F LAST McGuigan, SR.

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH 1 DAY 1 YEAR 1986

2b. HOUR 6 AM

3. SEX: M

4. RACE: W

5. DATE OF BIRTH: MONTH 6 DAY 11 YEAR 22

6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS. IF UNDER 1 YR.: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 1 DAY 1 YEAR 1986

2d. HOUR 6 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): USA

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HARFORD Memorial

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): –

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: CECIL ~~HARFORD~~

13c. CITY OR TOWN: CONOWINGO

13d. INSIDE CITY LIMITS? YES ☐ NO ☑

13e. STREET ADDRESS: 297 ~~Conowingo~~ ROCK SPRING RD 21918

14. FATHER'S NAME: FIRST WILLIAM MIDDLE PAUL LAST McGUIGAN

15. MOTHER'S MAIDEN NAME: FIRST MAE MIDDLE LAST HALBRUNER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO

16b. (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: ~~214~~ 214-20-8641

17. INFORMANT: DORIS J. McGUIGAN MD ADDRESS: CONOWINGO MD

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Luis E Reuse M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 1-1-86

EXAMINER'S NAME (TYPE OR PRINT): Luis E Reuse ADDRESS: 46 Williams St Havre de Grace

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 2-4-86

23c. NAME OF CEMETERY OR CREMATORY: CONOWINGO BAPTIST

23d. LOCATION CITY OR TOWN: CONOWINGO COUNTY: CECIL STATE: MD

24. FUNERAL DIRECTOR NAME: Robert Arnold Rising ADDRESS: 5014 MD

R.T. FOARD FUNERAL HOME

25a. DATE REC'D. BY REGISTRAR: JAN 3 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

035034

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 86 02083

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: WINIFRED MIDDLE: M LAST: McINTOSH | | 2a. DATE OF DEATH MONTH DAY YEAR: 1 29 1986 | 2b. HOUR: 7:30 P.M. |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH DAY YEAR: JANUARY 7, 1894 | 6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK CITY, N.Y. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD COUNTY MD. |
| 10. CITY OR TOWN OF DEATH: HAVRE DE GRACE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): CITIZENS NURSING HOME | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER | 12b. KIND OF BUSINESS OR INDUSTRY |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD | HARFORD | CHURCHVILLE | YES ☐ NO ☒ | 204 WHITE THORNE WAY 21028 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| LEWIS | REES | MORGAN | PRUDENCE | | OWEN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 226 03 8645D | WILLIAM B. McINTOSH | SAME AS #13e |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arterio sclerosis

DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular insufficiency

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from 10-3, 1984, to 1-29, 1986, that (I) (we) last saw the deceased alive on 12-10, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| H. Yamakawa | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 1/30/86 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| H. YAMAKAWA M.D. | 319 Va. Avenue Havre de Grace Md 21078 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| CREMATION | 30JANUARY86 | R. A. FERRIS & COMPANY | WEST CHESTER, PA. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078 | JAN 31 1986 | Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Page 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

035032

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 002084

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| EARL | BRUCE | MERRITT | January 29, 1986 | 4:00 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
|---|---|---|---|---|---|
| Male | White | Nov. 10, 1905 | 80 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Baltimore, Md. | USA | MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | Harford County MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Joppa | 1003 Magnolia Road | Watchman | Auto |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Harford | Joppa | YES ☐ NO ☒ | 1003 Magnolia Road 21085 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Melvin | M. | Merritt | Florence | -- | Miller |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WWII | 216-03-2778 | Juanita A. Merritt, 1003 Magnolia Road, Joppa | Md. 21085 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) RESPIRATORY FAILURE — 4 HOURS

DUE TO, OR AS A CONSEQUENCE OF (b) SQUAMOUS CELL CANCER (R) LUNG — 11 MONTHS

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| — | — | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | — |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from MARCH 19 84 (MARCH 1984) to JAN 29 19 86, that (I) (~~we~~) last saw the deceased alive on 12-27 19 85, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN | MEDICAL DIRECTOR | STAFF PHYSICIAN | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| John M. Lewin | M.D. | ☐ | ☒ | ☐ | 1-30-86 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| John Lewin | 6805 York Rd; Balt. MD. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | Feb.3,1986 | Blue Ridge Cemetery | Thurmont | Frederick | Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Howard K. McComas III | Abingdon, Md. 21009 | JAN 31 1986 | Gloria Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP.

DHMH - 16 60M 7/84
(VRA 15, 4)

020125

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 02085

REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST William MIDDLE Edgar LAST Miller

2a. DATE OF DEATH: MONTH DAY YEAR January 8, 1986 1-8-86

2b. HOUR: 4 A. M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH DAY YEAR August 10, 1905

6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford Co., MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): NONE

12b. KIND OF BUSINESS OR INDUSTRY: NONE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Harford Co.

13c. CITY OR TOWN: Bel Air (21014)

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 332 Giles Street 21014

14. FATHER'S NAME: FIRST Harry MIDDLE LAST Miller

15. MOTHER'S MAIDEN NAME: FIRST Elizabeth MIDDLE LAST Talbert

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): —

16b. SOCIAL SECURITY NO.: 213-62-6996

17. INFORMANT (Nephew) 836-9372 ADDRESS: 332 Giles Street
Mr. William B. Ambrose, Jr. Bel Air, Maryland 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ASCVD. Sensility

DUE TO, OR AS A CONSEQUENCE OF (b) Prostatic hypertrophy

DUE TO, OR AS A CONSEQUENCE OF (c) Dehydration

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____ to _____ 19_____ that (I) (we) last saw the deceased alive on _____ 19_____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]

DEGREE: M.D.

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/8/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): [signature]

22e. ADDRESS: Havre de Grace, Maryland 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: January 10, 1986

23c. NAME OF CEMETERY OR CREMATORY: Black Rock Cemetery

23d. LOCATION: CITY OR TOWN Butler COUNTY Balto. Co. STATE Maryland

24. FUNERAL DIRECTOR: Joseph William Foster ADDRESS: 50 W. Broadway & Williams St. Bel Air, Maryland 21014

25a. DATE REC'D. BY REGISTRAR: JAN 13 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 4 and return it to the Vital Records Division. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

020126

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 0 2 0 8 0

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST William MIDDLE Gale LAST Miller | | 2a. DATE OF DEATH MONTH DAY YEAR 1-12-86 | 2b. HOUR 11 a.m. |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 12 7 10 | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia Mendota | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. |
| 10. CITY OR TOWN OF DEATH Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | 12b. KIND OF BUSINESS OR INDUSTRY Agriculture |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | 13b. COUNTY Harford Co. | 13c. CITY OR TOWN Bel Air | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS / ZIP CODE 304 Locust Lane 21014 |
| 14. FATHER'S NAME FIRST John MIDDLE LAST Miller | | 15. MOTHER'S MAIDEN NAME FIRST Dora MIDDLE Mae LAST Fleenor | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | (IF YES, GIVE WAR OR DATES) — | 16b. SOCIAL SECURITY NO. 186-14-3409 | 17. INFORMANT (WIFE) 838-7650 ADDRESS 304 Locust Lane Mrs. A. Blanche Miller Bel Air, Maryland 21014 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Stroke

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular disease

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE Joseph Reinhardt DEGREE | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED 1-12-86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Reinhardt, M.D. | 22e. ADDRESS 2003 Rock Spring Road, Forest Hill, Maryland 21050 | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Jan. 14, 1986 | 23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens | 23d. LOCATION CITY OR TOWN Bel Air, COUNTY Harford Co., STATE Maryland 21014 |
| 24. FUNERAL DIRECTOR Joseph William Foster ADDRESS 50 W. Broadway & Williams St, Bel Air, Maryland 21014 | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1986 | 25b. REGISTRAR'S SIGNATURE Julia Davidson Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the copy of papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

B

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

024011

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 02087

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: LOLA MIDDLE: LORAINE LAST: MINOR | | 2a. DATE OF DEATH MONTH DAY YEAR: January 19, 1986 | 2b. HOUR: 12:25 PM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Dec. 4, 1947 | 6. AGE (IN YEARS LAST BIRTHDAY): 38 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Florida | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. |
| 10. CITY OR TOWN OF DEATH: Joppa | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 305 Sheffield Court | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Research Assistant, | 12b. KIND OF BUSINESS OR INDUSTRY: Univ. Johns Hopkins |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE: Maryland | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Joppa | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET ADDRESS / ZIP CODE: 305 Sheffield Court 21085 |

| | |
|---|---|
| 14. FATHER'S NAME FIRST MIDDLE LAST: James Edison Lott | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Lola M. Goad |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No; (IF YES, GIVE WAR OR DATES): -- | 16b. SOCIAL SECURITY NO.: 263-02-3959 |
| 17. INFORMANT: Dr. Thomas C. Monor | ADDRESS: Joppa, Md. 21085, 305 Sheffield Court |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | metastatic carcinoma of liver | 6 months |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Cancer of the pancreas | 2 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 4/15/80, 19__, to 11/19, 19 86, that (I) (~~we~~) last saw the deceased alive on 4/15 1986, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Emory J. Linder; DEGREE: MD; ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | | 22c. DATE SIGNED: 1/20/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Emory J. Linder, M.D. | 22e. ADDRESS: 902 Averill Road, Joppa, Md. 21085 | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Jan. 22, 1986 | 23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Episcopal Cem. | 23d. LOCATION CITY OR TOWN: Abingdon; COUNTY: Harford; STATE: Md. |
| 24. FUNERAL DIRECTOR NAME: Howard K. McComas III | ADDRESS: Abingdon, Md. 21009 | 25a. DATE REC'D BY REGISTRAR: JAN 22 1986 | 25b. REGISTRAR'S SIGNATURE: Lucie Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours ... page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before any other death ...

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

036094

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 0 2 0 8 8

1. DECEASED NAME (TYPE OR PRINT) FIRST Henry MIDDLE Perry LAST Mitchell, Sr.
Henry P Mitchell

2a. DATE OF DEATH MONTH 1 DAY 31 YEAR 86
2b. HOUR 8:20 A.M.

3. SEX: Male
4. RACE: White
5. DATE OF BIRTH MONTH 2 DAY 18 YEAR 15
6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Cedar Bluff, Va.
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.
10. CITY OR TOWN OF DEATH: Fallston
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Custodian
12b. KIND OF BUSINESS OR INDUSTRY: US-govt.Ret.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: Abingdon
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS / ZIP CODE: 3637 Woodsdale Road 21009

14. FATHER'S NAME FIRST Zachariah MIDDLE Taylor LAST Mitchell
15. MOTHER'S MAIDEN NAME FIRST Hannah MIDDLE Jane LAST Sparks
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WWII
16b. SOCIAL SECURITY NO. 234-20-4765
17. INFORMANT: Henry P.Mitchell,Jr., ADDRESS Millersville,Md. 21108

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ELECTRO MECHANICAL ASSOC
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MI — 10 hrs
DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE — 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/30 19 86, to 1/31 19 86, that (I) (we) last saw the deceased alive on 1/31 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]
22c. DATE SIGNED 1/31/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Marilyn J Mowry
22e. ADDRESS: Fallston General Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Feb.3,1986
23c. NAME OF CEMETERY OR CREMATORY: Holly Hill Memorial Gardens,
23d. LOCATION CITY OR TOWN: Baltimore COUNTY: — STATE: Md.
24. FUNERAL DIRECTOR NAME: Howard K. McComas III, ADDRESS: Abingdon,Md. 21009
25a. DATE REC'D. BY REGISTRAR: FEB 03 1986
25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

020127

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 86 020089

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Norman MIDDLE: CHRISTIAN LAST: Moore, SR.

2a. DATE OF DEATH — MONTH: January DAY: 13 YEAR: 1986

2b. HOUR: 12:03P M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH — MONTH: Oct. DAY: 10, YEAR: 1917

6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Hoxsie, R.I.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford Co. MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanical engineer, USGovt.Ret.

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Harford

13c. CITY OR TOWN: Abingdon

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 1217 Abinchar Drive 21009

14. FATHER'S NAME — FIRST: David MIDDLE: Smith LAST: Moore, Jr.

15. MOTHER'S MAIDEN NAME — FIRST: Christine MIDDLE: M. M. LAST: Jacobsen

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): --

16b. SOCIAL SECURITY NO.: 039-03-9852

17. INFORMANT: Mrs. Natalie Moore, 1217 Abinchar Drive, ADDRESS: Abingdon, Md. 21009

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) metastatic carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of rectum — 13 YRS

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from Jan 10, 19 86, to Jan 13, 19 86, that (I) (~~we~~) last saw the deceased alive on Jan 13, 19 86, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: B J Shuckett Jr MD — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [✓] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 1-13-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Jan. 16, 1986

23c. NAME OF CEMETERY OR CREMATORY: Harford Mem. Gardens

23d. LOCATION — CITY OR TOWN: Aldino COUNTY: Harford STATE: Md.

24. FUNERAL DIRECTOR — NAME / ADDRESS: Howard K. McComas III, Abingdon, Md. 21009

25a. DATE REC'D. BY REGISTRAR: JAN 16 1986

25b. REGISTRAR'S SIGNATURE: [signature]

009190

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 2 0 9 0

1. DECEASED NAME (TYPE OR PRINT): FIRST HARLAN MIDDLE Murray LAST MORGAN

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH 1 DAY 1 YEAR 1986

2b. HOUR 2:32 A.M.

3. SEX: M

4. RACE: W

5. DATE OF BIRTH: MONTH 6 DAY 14 YEAR 32

6. AGE (IN YEARS LAST BIRTHDAY): 53 YRS.

IF UNDER 1 YR.: MONTHS ___ DAYS ___

IF UNDER 24 HRS.: HOURS ___ MIN. ___

2c. DATE PRONOUNCED DEAD: MONTH 1 DAY 1 YEAR 1986

2d. HOUR 2:32 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): USA

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HARFORD Memorial

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Md

13b. COUNTY (HARFORD)

13c. CITY OR TOWN Havre de Grace

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS 416 Battery Dr. 21078

14. FATHER'S NAME: FIRST Harry MIDDLE LAST Morgan

15. MOTHER'S MAIDEN NAME: FIRST Helen MIDDLE I. LAST Griffith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) V-N

16b. SOCIAL SECURITY NO. 218-28-0889

17. INFORMANT: Hospital Records ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Heart Disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Luis E Renzel M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 7-1-86

EXAMINER'S NAME (TYPE OR PRINT) LUIS E Renzel ADDRESS 464 Alliance St. Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Jan. 4, 1986

23c. NAME OF CEMETERY OR CREMATORY: Harford Mem. Gdns.

23d. LOCATION CITY OR TOWN COUNTY STATE: Aberdeen, Harford, Maryland

24. FUNERAL DIRECTOR NAME ADDRESS: Tarring Funeral Home, PA., Aberdeen, MD, 21001-3399

25a. DATE REC'D. BY REGISTRAR: JAN 7 1986

25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP ___ DHMH - 17 (VR A15 ME (5))

028012

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

86 02091

REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Charles MIDDLE C. LAST Nelson SR. | | 2a. DATE OF DEATH MONTH DAY YEAR January 20 1986 | 2b. HOUR 2:30 PM |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 26, 1896 | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. — IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KT. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. |
| 10. CITY OR TOWN OF DEATH Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET)SELF-EMPLOYED | 12b. KIND OF BUSINESS OR INDUSTRY MOTEL OWNER |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD | HARFORD | HAVRE de GRACE | YES ☒ NO ☐ | 500 CONGRESS AVE. 21078 |

| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
|---|---|---|---|---|---|
| FIRST JESSE | MIDDLE O. | LAST NELSON | FIRST LAURA | MIDDLE E. | LAST |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | WW I | 218 32 3061 | CHARLES C. NELSON, JR. | 620 S.E. 5th Ct. POMPANO BEACH, FL. 33060 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC

DUE TO, OR AS A CONSEQUENCE OF (c) HEART DISEASE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Interstitial Lung Disease

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from 1/15 1986 to 1/20 1986 that (I) (we) last saw the deceased alive on 1/20 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Dante Monakil | — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 1/20/86 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DANTE N. MONAKIL | Havre de Grace, Md 21078 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| BURIAL | 24JANUARY86 | ANGEL HILL CEMETERY | HAVRE de GRACE, HARFORD CO., MD. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| MITCHELL FUNERAL HOME PA | HAVRE de GRACE, MD. 21078 | JAN 24 1986 | |

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

020123

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 86 002092

1. DECEASED NAME (TYPE OR PRINT) FIRST BARBARA MIDDLE JEAN NICHOLSON
BARBARA NICHOLSON

2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH DAY YEAR 1-13-86 19 — 2b. HOUR M

3. SEX Female — 4. RACE White — 5. DATE OF BIRTH MONTH DAY YEAR July 14, 1967 — 6. AGE (IN YEARS LAST BIRTHDAY) 18 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-13-86 19 — 2d. HOUR 6:40P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] — 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.

10. CITY OR TOWN OF DEATH Fallston — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Quality Serv.Control — 12b. KIND OF BUSINESS OR INDUSTRY Restaurant

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland — 13b. COUNTY Harford — 13c. CITY OR TOWN Edgewood — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS 639 Hornbeam Road 21040

14. FATHER'S NAME FIRST William MIDDLE Joseph LAST Nicholson — 15. MOTHER'S MAIDEN NAME FIRST Ellarie MIDDLE -- LAST Longnecker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no — (IF YES, GIVE WAR OR DATES) -- — 16b. SOCIAL SECURITY NO. 218-92-9194 — 17. INFORMANT Mrs.Ellarie Nicholson, — ADDRESS Edgewood,Md.21040 639 Hornbeam Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:

8120

IMMEDIATE CAUSE (a) Multiple injuries

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 3:15PM 1-13-86 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of a vehicle in collison with another vehicle

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hgwy. — 21f. LOCATION STREET Rt. #22@ Tudor Lane CITY OR TOWN Belair COUNTY STATE Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE Margarita A. Korell M.D. — TITLE (SPECIFY) Assistant MEDICAL EXAMINER — DATE SIGNED 1-14-86

EXAMINER'S NAME (TYPE OR PRINT) Margarita A.Korell,M.D. — ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — 23b. DATE Jan.17,1986 — 23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens — 23d. LOCATION CITY OR TOWN Bel Air — COUNTY Harford — STATE Md.

24. FUNERAL DIRECTOR NAME Howard K. McComas III, — ADDRESS Abingdon, Md. 21009 — 25a. DATE REC'D. BY REGISTRAR JAN 16 1986 — 25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY QUESTIONS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

035031

1 - FOR STATE REGISTRAR

STATE OF MARYLAND 86 02093
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: HATSUE MIDDLE: — LAST: ONO

2a. DATE OF DEATH MONTH DAY YEAR: JAN. 23 86

2b. HOUR: 3:08 PM

3. SEX: Female

4. RACE: Oriental

5. DATE OF BIRTH MONTH DAY YEAR: Dec. 24, 1900

6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Japan

7b. CITIZEN OF WHAT COUNTRY?: Japan

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Harford

13c. CITY OR TOWN: Aberdeen

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 622 Rodgers St. 21001

14. FATHER'S NAME FIRST MIDDLE LAST: UNK

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: UNK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 800-23-7245

17. INFORMANT ADDRESS: Jack G. Walker, 622 Rogers St., Aberdeen, MD, 21001

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac decompensation

DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatic heart disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Mitral stenosis, aortic regurgitation

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-30 1985 to 1-23 1986, that (I) (we) last saw the deceased alive on 1-20 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]

DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/23/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): H. AMAKAWA M.D.

22e. ADDRESS: 319 So. Union Ave. Havre de Grace Md. 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Jan. 27, 1986

23c. NAME OF CEMETERY OR CREMATORY: Harford Mem. Gdns.

23d. LOCATION CITY OR TOWN COUNTY STATE: Aberdeen, Harford, Maryland

24. FUNERAL DIRECTOR NAME ADDRESS: Tarring Funeral Home, PA, Aberdeen, MD, 21001-3399

25a. DATE REC'D. BY REGISTRAR: JAN 31 1986

25b. REGISTRAR'S SIGNATURE: Celia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

022098

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 02094

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Eva MIDDLE: Ann LAST: Preston

2a. DATE OF DEATH MONTH 1 DAY 13 YEAR 86

2b. HOUR 2:10 P.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: July 26, 1911

6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.

10. CITY OR TOWN OF DEATH: Fallston

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Harford

13c. CITY OR TOWN: White Hall

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 4454 Norrisville Rd 21161

14. FATHER'S NAME FIRST: John MIDDLE: LAST: Szymanska

15. MOTHER'S MAIDEN NAME FIRST: Victoria MIDDLE: LAST: Seragny

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 215-03-9208

17. INFORMANT: J. Earl Preston ADDRESS: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b): Severe Heart failure

DUE TO, OR AS A CONSEQUENCE OF (c): COPD, Cerebrovascular

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CIS, electrolyte imbalance.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/24, 1985, to 1/13, 1986, that (I) (we) last saw the deceased alive on 1/13, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]

DEGREE: M.D

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1-13-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): V.S. NAIR M.D

22e. ADDRESS: 2112 Bel air Road. Fallston MD 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1/16/1986

23c. NAME OF CEMETERY OR CREMATORY: Highview Mem. Gar.

23d. LOCATION CITY OR TOWN COUNTY STATE: Fallston, Harford, Md.

24. FUNERAL DIRECTOR: M. Gladden Kurtz ADDRESS: Jarrettsville, Md.

25a. DATE REC'D. BY REGISTRAR: JAN 16 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson Rodgers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

037021

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 0 2 0 9 5

1. DECEASED NAME (TYPE OR PRINT): FIRST Clara MIDDLE H. LAST Price

2a. DATE OF DEATH: MONTH 1 DAY 26 YEAR 86

2b. HOUR 445p M

3. SEX: F

4. RACE: C

5. DATE OF BIRTH: MONTH 11 DAY 08 YEAR 07

6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. IF UNDER 1 YEAR: MONTHS: DAYS: IF UNDER 24 HRS.: HOURS: MIN.:

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Cumberland, Md.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.

10. CITY OR TOWN OF DEATH: Fallston

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Homemaking

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Harford

13c. CITY OR TOWN: Edgewood

13d. INSIDE CITY LIMITS? YES [ ] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 1950 Sidnee Drive 20140

14. FATHER'S NAME: FIRST William MIDDLE F. LAST Roberts

15. MOTHER'S MAIDEN NAME: FIRST Cornelia MIDDLE LAST Floyd

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 213-30-5205

17. INFORMANT: Lloyd Price ADDRESS: 1950 Sidnee Dr. Edgewood 21040

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory arrest (Post Code)

DUE TO, OR AS A CONSEQUENCE OF (b) Acute Resp' Failure.

DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia ~~Bilateral~~ Pneumothorax, Atelectasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Multiple Myeloma - PANCYTOPENIA - Spinal Cord Compression with paraplegia

19a. DATE OF OPERATION: —

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/26/86 to 1/26/86 that (I) (we) last saw the deceased alive on 1/26/86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: D. L. Pirovolidis DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 1/27/86.

22d. PHYSICIAN'S NAME (TYPE OR PRINT): D. L. PIROVOLIDIS

22e. ADDRESS: 2112 Bel Air Rd. FALLSTON, Md. 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1-29-86

23c. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Baltimore County, Md.

24. FUNERAL DIRECTOR NAME: Lassahn Funeral Home ADDRESS: 7401 Belair Rd. BALTO. MD. 21236

25a. DATE REC'D BY REGISTRAR: FEB 04 1986

25b. REGISTRAR'S SIGNATURE: Barbara Rondale

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

020122

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 2 0 1 2 2

1 - FOR STATE REGISTRAR Robert Crump Rex

REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Robert MIDDLE crump LAST Rex | | | 2a. DATE OF DEATH MONTH 1 DAY 7 YEAR 86 | | 2b. HOUR 5:00 A M |
| 3. SEX male | 4. RACE W | 5. DATE OF BIRTH MONTH 3 DAY 15 YEAR 13 | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | | |
| 10. CITY OR TOWN OF DEATH Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager | 12b. KIND OF BUSINESS OR INDUSTRY Martin M. Co. | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD | Harford | Bel Air | YES ☐ NO ☐ | 408 Chadford Ct 21014 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST Albert MIDDLE L. LAST Rex | | 15. MOTHER'S MAIDEN NAME FIRST Mattie MIDDLE F. LAST Crump | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. 213-10-2965 | 17. INFORMANT Mrs. Mary L. Rex, ADDRESS 408 Chadford Ct. Belair, Md. 21014 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adeno CA Lung with pleural Effusion
DUE TO, OR AS A CONSEQUENCE OF (b) and multiple Bone mets.
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6-months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Aug 19 85, to 1-6 19 86, that (I) (we) last saw the deceased alive on 1-6 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE [signature] | DEGREE MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED 1-7-86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. PAREKH MD. | 22e. ADDRESS 1908 HARFORD RD, FALLSTON MD. 21047 | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE 1-7-1986 | 23c. NAME OF CEMETERY OR CREMATORY Westview Crematory | 23d. LOCATION CITY OR TOWN Balto. COUNTY Md. STATE |
| 24. FUNERAL DIRECTOR NAME E.F. Lassahn, ADDRESS 11750 Belair Rd. Kingsville, Md. 2108 | | 25a. DATE REC'D. BY REGISTRAR JAN 13 1986 | 25b. REGISTRAR'S SIGNATURE [signature] |

014130

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 0 0 2 0 9 7

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST JOHN MIDDLE G. LAST REYERSON | | 2a. DATE OF DEATH MONTH DAY YEAR 01-08-86 | 2b. HOUR 5:23 PM |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 09-19-18 | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD Co. MD. |
| 10. CITY OR TOWN OF DEATH Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INSURANCE SALESMAN | 12b. KIND OF BUSINESS OR INDUSTRY INSURANCE |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| MD | HARFORD | BEL AIR | YES ☐ NO ☒ | 605 FOXCROFT DR 21014 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| THEODORE | | REYERSON | MARY | | SCHONHOFF |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | WW II | 220-01-2265 | MARY AGNES REYERSON (WIFE) | SAME ADDRESS |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic renal failure

DUE TO, OR AS A CONSEQUENCE OF (c) Ventricular arrhythmia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (the hospital) attended the deceased from 6/1/85 to 1/8/86 that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT) LINDA FREILICH MD — 22e. ADDRESS 1604 Churchville Road

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| BURIAL | 1/11/86 | BELAIR MEM. GARDENS | BALTO. | | MD. |

| 24. FUNERAL DIRECTOR NAME AND ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SCHIMUNEK FUNERAL HOME, INC. 9705 Belair Rd., Balto. Md. 21236 | JAN 10 1986 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

024187

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 86 02098

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Harry MIDDLE: D LAST: Roesinger | | 2a. DATE OF DEATH MONTH 1 DAY 15 YEAR 86 | 2b. HOUR M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH 8 DAY 30 YEAR 17 | 6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD. |
| 10. CITY OR TOWN OF DEATH: Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1303 Murgatroyd Rd. Fallston | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret.Letter Car. | 12b. KIND OF BUSINESS OR INDUSTRY: US Postal Ser. |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE: Maryland | 13b. COUNTY: Harford | 13c. CITY OR TOWN: | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS / ZIP CODE: 1303 Murgatroyd Rd. Fallston 21047 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST: Harry MIDDLE: LAST: Roesinger | | 15. MOTHER'S MAIDEN NAME FIRST: Anna MIDDLE: L. LAST: Harms | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES): WW 11 217-07-3930 | 17. INFORMANT: Ruth A. Roesinger | ADDRESS: 1303 Murgatroyd Rd. Fallston, Md. 21047 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(b) Carcinoma metastatics lymph nodes and liver

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 12/19 19 85 to 1/15 19 86, that (I) (we) last saw the deceased alive on 1/15 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Joan Edwards | DEGREE: MD | 22c. DATE SIGNED: 1/16/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOAN P EDWARDS | 22e. ADDRESS: 2117 BELAIR RD FALLSTON MD 21047 | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 1-18-86 | 23c. NAME OF CEMETERY OR CREMATORY: Highview Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Harford Co., Maryland |
| 24. FUNERAL DIRECTOR NAME: Hassahn Funeral Home | ADDRESS: 7401 Belair Rd. BALTO. MD. 21236 | 25a. DATE REC'D. BY REGISTRAR: JAN 20 1986 | 25b. REGISTRAR'S SIGNATURE: Davidson Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

021017

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 86 002097

1. DECEASED NAME (TYPE OR PRINT) — FIRST: John — MIDDLE: M — LAST: ROMAN

2a. DATE OF DEATH — KNOWN ☐ ESTIMATED ☐ — MONTH 1 DAY 20 YEAR 19 86

2b. HOUR 9 a.m. ☒ p.m. ☐

3. SEX: M

4. RACE: W

5. DATE OF BIRTH — MONTH J DAY 23 YEAR 20

6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS.

IF UNDER 1 YR. — MONTHS: ; DAYS:

IF UNDER 24 HRS. — HOURS: ; MIN.:

2c. DATE PRONOUNCED DEAD — MONTH 1 DAY 20 YEAR 19 86

2d. HOUR 9 a.m. ☒ p.m. ☐

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pa

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HARFORD MEMORIAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): VETERAN

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: Cecil

13c. CITY OR TOWN: Colora

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 2625 Tome Hwy. 21917

14. FATHER'S NAME — FIRST: JOHN — MIDDLE: MARTIN — LAST: ROMAN

15. MOTHER'S MAIDEN NAME — FIRST: ANNA — MIDDLE: — LAST: HAYOSTEK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 172-18-9423

17. INFORMANT: Hospital Records. ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Luis E Renjel M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 1-20-86

EXAMINER'S NAME (TYPE OR PRINT): LUIS E RENJEL ADDRESS: 464 Williams St Havre de Grace 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 24JANUARY86

23c. NAME OF CEMETERY OR CREMATORY: ST. MARY'S CEMETERY

23d. LOCATION — CITY OR TOWN: PORTAGE — COUNTY: CAMBRIA CO. — STATE: PA.

24. FUNERAL DIRECTOR — NAME: SERENKO FUNERAL HOME — ADDRESS: PORTAGE, PA 15946

MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078

25a. DATE REC'D. BY REGISTRAR: JAN 22 1986

25b. REGISTRAR'S SIGNATURE:

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1-2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM M-3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP_____

DHMH-17
(VR A15 ME(5))
15M 2/80

031065

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND 86-021 00
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST C. MIDDLE L. LAST Roseberry

2a. DATE OF DEATH: MONTH DAY YEAR Jan. 23, 1986 1-23-86

2b. HOUR 11:00 P.M.

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH DAY YEAR 2 4 22

6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY? USA.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.

10. CITY OR TOWN OF DEATH: Fallston

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): Retired Plumbing Foreman Chief

12b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Harford

13c. CITY OR TOWN: Bel Air

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 204 Plumtree 21014

14. FATHER'S NAME: FIRST Roy MIDDLE L. LAST Roseberry

15. MOTHER'S MAIDEN NAME: FIRST Pauline MIDDLE LAST Edwards

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES - Air Force (IF YES, GIVE WAR OR DATES): WW2

16b. SOCIAL SECURITY NO.: 228-16-0351

17. INFORMANT (WIFE) 838-7424 ADDRESS 204 Plumtree Road
Mrs. Jewel B. Roseberry Bel Air, Maryland 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b) General debilitation

DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the lung

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/18 19 86 to 1/23 19 86, that (I) (we) last saw the deceased alive on 1/25 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 1/24/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Robert Smith

22e. ADDRESS: Fallston Gen. Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Jan. 27, 1986

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

23d. LOCATION: CITY OR TOWN Bel Air, COUNTY Harford Co., STATE Maryland 21014

24. FUNERAL DIRECTOR: Joseph William Foster
ADDRESS 50 W. Broadway & Williams St.
Bel Air, Maryland 21014

25a. DATE REC'D. BY REGISTRAR: JAN 27 1986

25b. REGISTRAR'S SIGNATURE: John Dwyer

024014

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 86 02 101

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: William MIDDLE: Alexander LAST: Russell Sr. | | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH DAY YEAR: 1-19 1986 | 2b. HOUR: 11a 00 M |
| 3. SEX: M | 4. RACE: W | 5. DATE OF BIRTH MONTH DAY YEAR: 2 14 16 | 6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN |
| 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 1- 19 1986 | 2d. HOUR: 1p M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NJ | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. |
| 10. CITY OR TOWN OF DEATH: Aberdeen | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 206 S. Parke St. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired | 12b. KIND OF BUSINESS OR INDUSTRY: US Gov't. |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | |
| 13a. STATE: MD | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Aberdeen | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS: 206 S. Parke St. 21001 |
| 14. FATHER'S NAME FIRST: John MIDDLE: E. LAST: Russell | | 15. MOTHER'S MAIDEN NAME FIRST: Eva MIDDLE: LAST: Wershing | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES | (IF YES, GIVE WAR OR DATES): WWII | 16b. SOCIAL SECURITY NO.: 151-01-6149 | 17. INFORMANT: Personal papers ADDRESS: |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Heart Disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☐ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE L Renjel M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 1-20-86

EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D. ADDRESS 464 Alliance St. HavreDeGrace, MD

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Jan.22,1986 | 23c. NAME OF CEMETERY OR CREMATORY: Harford Mem. Gdns. | 23d. LOCATION CITY OR TOWN COUNTY STATE: Aberdeen,Harford,Maryland |
| 24. FUNERAL DIRECTOR NAME ADDRESS: Tarring Funeral Home,P.A.,Aberdeen,MD,21001-3399 | | 25a. DATE REC'D. BY REGISTRAR: JAN 22 1986 | 25b. REGISTRAR'S SIGNATURE |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. NO DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 4. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

017038

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 2 1 0 2

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ROBERT — MIDDLE: WALKER — LAST: SAMPSON, JR.

2a. DATE OF DEATH — KNOWN [X] ESTIMATED [ ] — MONTH DAY YEAR: 1-12-86 19 — 2b. HOUR: M

2c. DATE PRONOUNCED DEAD — MONTH DAY YEAR: 1-12-86 19 — 2d. HOUR: 9:20A M

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH MONTH DAY YEAR: 4 26 67 — 6. AGE (IN YEARS LAST BIRTHDAY): 18 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED [ ] NEVER MARRIED [XX] WIDOWED [ ] DIVORCED [ ] — 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.

10. CITY OR TOWN OF DEATH: Joppa Maryland — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Rt. 7 and Rt. 152 — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Apprentice — 12b. KIND OF BUSINESS OR INDUSTRY: Printing

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland — 13b. COUNTY: ——— — 13c. CITY OR TOWN: Baltimore — 13d. INSIDE CITY LIMITS? YES [XX] NO [ ] — 13e. STREET ADDRESS: 3120 Fait Avenue 21224

14. FATHER'S NAME — FIRST: Robert — MIDDLE: Walker — LAST: Sampson Sr.

15. MOTHER'S MAIDEN NAME — FIRST: Patricia — MIDDLE: Ann — LAST: Pisani

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): ——— — 16b. SOCIAL SECURITY NO.: 212-04-8295

17. INFORMANT: Robert W. Sampson Sr. — ADDRESS: 3120 Fait Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

8120

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 7:55AM 1-12-86 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): driver of auto/fixed object collision

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): hgwy. — 21f. LOCATION STREET: Rt. 7 and 152 — CITY OR TOWN: Joppa, Maryland — STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE OF M.D.: Margarita A. Korell — TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 1-12-86

EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. — ADDRESS: 111 PennStreet

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 1-15-86 — 23c. NAME OF CEMETERY OR CREMATORY: Sacred Heart of Jesus — 23d. LOCATION CITY OR TOWN: Dundalk, COUNTY: Balto. Co., STATE: Md.

24. FUNERAL DIRECTOR NAME: Charles S. Zeiler & Son Inc. — ADDRESS: 901 S. Conkling St. — 25a. DATE REC'D BY REGISTRAR: JAN 14 1986 — 25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WHEN REQUIRED, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP____

DHMH - 17 (VR A15 ME (5))

028126

86 02103

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Geneva MIDDLE: R LAST: Sconion

2a. DATE OF DEATH MONTH DAY YEAR: Jan. 18, 1986

2b. HOUR: 8:10 AM

3. SEX: F

4. RACE: B

5. DATE OF BIRTH MONTH DAY YEAR: 12 21 48

6. AGE (IN YEARS LAST BIRTHDAY): 37 YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Disabled

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Harford

13c. CITY OR TOWN: Havre De Grace

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 800 Garfield Road 21078

14. FATHER'S NAME FIRST: Ollie MIDDLE: LAST: Pope

15. MOTHER'S MAIDEN NAME FIRST: Geneva MIDDLE: LAST: Spriggs

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 220-50-2518

17. INFORMANT: Phillip Richard Sconion, Sr. ADDRESS: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF (b): Lupus Erythematosus and

DUE TO, OR AS A CONSEQUENCE OF (c): Scleroderma

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/15 1986 to 1/18 1986 that (I) (we) last saw the deceased alive on 1/18/86 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Edward Yun DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 1/18/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN D YUN

22e. ADDRESS: Havre de Grace Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1-23-86

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

23d. LOCATION CITY OR TOWN: Bel Air COUNTY: Harford STATE: Md.

24. FUNERAL DIRECTOR NAME: Arnold Beard ADDRESS: 353 Fountain St. HavreDeGrace, Md.

25a. DATE REC'D BY REGISTRAR: JAN 24 1986

25b. REGISTRAR'S SIGNATURE: [illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or medical examiner, it must be filed in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 50M 4/83 (VRA 15, 4)

030007

#3, 6 per FN 112186 Kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 002104

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Dorothy; MIDDLE: ; LAST: Shauck | | 2a. DATE OF DEATH — KNOWN ☐ ESTIMATED ☒: MONTH 1 DAY 23 YEAR 19 86 | 2b. HOUR 11:40 p.m. |
| 3. SEX: F | 4. RACE: W | 5. DATE OF BIRTH: MONTH 6 DAY 14 YEAR 09 | 6. AGE (IN YEARS LAST BIRTHDAY): 76 77 YRS. IF UNDER 1 YR.: MONTHS / DAYS / HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: MONTH 1 DAY 24 YEAR 19 86 | 2d. HOUR 7:30 a.m. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ seperated | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. | | |
| 10. CITY OR TOWN OF DEATH: Abingdon | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 419 Chrisfield Dr. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Rec. Clerk | 12b. KIND OF BUSINESS OR INDUSTRY: Montgomery Ward | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Abingdon | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 419 Chrisfield Drive 21009 | |
| 14. FATHER'S NAME FIRST: James; MIDDLE: H; LAST: Stouter | | | 15. MOTHER'S MAIDEN NAME FIRST: Mary; MIDDLE: E; LAST: Hassell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 216-24-2943 | 17. INFORMANT: Yvonne Blasco (dghtr) | ADDRESS: same address | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

(b) ASCVD

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☐ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Luis E. Renjel M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 1-24-86

EXAMINER'S NAME (TYPE OR PRINT): Luis E. Renjel, M.D. ADDRESS: 464 Alliance St. Havre De Grace, Md

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 1/27/86 | 23c. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem. | 23d. LOCATION CITY OR TOWN: Baltimore COUNTY: STATE: Md. |
| 24. FUNERAL DIRECTOR NAME: Schimunek Funeral Home, Inc. ADDRESS: 9705 Belair Rd., Balto. Md. 21236 | | 25a. DATE REC'D BY REGISTRAR: JAN 28 1986 | 25b. REGISTRAR'S SIGNATURE: [illegible] |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

017002

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 002105

REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST THURMAN MIDDLE THEODORE LAST SNYDER | | 2a. DATE OF DEATH MONTH DAY YEAR January 13, 1986 | 2b. HOUR 4:50 AM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR November 7, 1910 | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS; IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rowan, N.C. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. |
| 10. CITY OR TOWN OF DEATH Joppa | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) 1101 Oak Avenue | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder | 12b. KIND OF BUSINESS OR INDUSTRY Self-employed |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE Maryland | 13b. COUNTY Harford | 13c. CITY OR TOWN Joppa | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS / ZIP CODE 1101 Oak Avenue 21085 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST Philip MIDDLE Hosia LAST Snyder | | 15. MOTHER'S MAIDEN NAME FIRST Fannie MIDDLE Evelyn LAST Roberts | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | (IF YES, GIVE WAR OR DATES) -- | 16b. SOCIAL SECURITY NO. 245-12-9235 | 17. INFORMANT ADDRESS Mrs.Melba Stancill, 1131 Clayton Road, Joppa, Md 21085 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) metastatic cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 month

DUE TO, OR AS A CONSEQUENCE OF (b) cancer of lung — 2 months

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this physician) attended the deceased from 12-10 19 85 to 1/13 19 86 that (I) (we) last saw the deceased alive on 1/12 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE Emory Linder | DEGREE ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | | 22c. DATE SIGNED 1-13-86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Emory J. Linder, M.D. | | 22e. ADDRESS 902 Averill Road, Joppa, Md. 21085 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Jan.15,1986 | 23c. NAME OF CEMETERY OR CREMATORY Harford Mem.Gardens | 23d. LOCATION CITY OR TOWN Aldino | COUNTY Harford / STATE Md. |
| 24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009 | | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1986 | 25b. REGISTRAR'S SIGNATURE |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

028160

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 86 002106

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Victor MIDDLE: -------- LAST: Soboda | | 2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ MONTH 1-17 DAY YEAR 19 86 | 2b. HOUR M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Feb. 1, 1926 | 6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN. |
| 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 1-17 19 86 | 2d. HOUR: 9:30 a. M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Czechslovakia | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County, MD. |
| 10. CITY OR TOWN OF DEATH: Aberdeen | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): I-95, 182 mile marker | 12a. USUAL OCCUPATION (TYPE OF WORK DURING MOST OF WORKING LIFE): Factory Representative | 12b. KIND OF BUSINESS OR INDUSTRY: Photographic Equipment |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | |
| 13a. STATE: Virginia | 13b. COUNTY: Fairfax | 13c. CITY OR TOWN: Reston | 13d. INSIDE CITY LIMITS? YES ☐ NO XX; 13e. STREET ADDRESS: 2181 Pond View Court |
| 14. FATHER'S NAME FIRST: Theodore MIDDLE: LAST: Soboda | | 15. MOTHER'S MAIDEN NAME FIRST: Matilda MIDDLE: LAST: Halik | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 554-50-4712 | 17. INFORMANT: Ludmila Soboda, 2181 Pond View Court ADDRESS: Reston, Virginia | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Injuries
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO XX |
| 21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: 9:15 XX 1-17 19 86 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): driver in multiple vehicle impact |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road | 21f. LOCATION STREET: I-95, 182 mile marker; CITY OR TOWN: Aberdeen; COUNTY: Harford Co.; STATE: Md. |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection XX, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED 1-18-86

EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: 1/19/86 | 23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory | 23d. LOCATION CITY OR TOWN: Alexandria COUNTY: STATE: VA |
| 24. FUNERAL DIRECTOR NAME: J. Berkley Green ADDRESS: 721 Elden St., Herndon, VA | | 25a. DATE REC'D. BY REGISTRAR: JAN 23 1986 | 25b. REGISTRAR'S SIGNATURE: [signature] |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 3. RETAIN PAGE 3 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

999999

07/84 25M BP DHMH 17 (VR A15 ME (5))

037032

STATE OF MARYLAND 86 02107
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: SUSIE MIDDLE: Y. LAST: Stemple

2a. DATE OF DEATH MONTH JAN DAY 29 YEAR 1986

2b. HOUR 9:45 P.M.

3. SEX: Female

4. RACE: WHITE

5. DATE OF BIRTH MONTH 7 DAY 13 YEAR 1900

6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. VA.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY: HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Cecil

13c. CITY OR TOWN: Rising Sun

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE: P.O. Box 9 21911

14. FATHER'S NAME FIRST: ANDREW MIDDLE: S. LAST: FOGLE

15. MOTHER'S MAIDEN NAME FIRST: MINERVA MIDDLE: LAST: COCHRAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): — — —

16b. SOCIAL SECURITY NO.: 197-07-9078

17. INFORMANT: FRED A. STEMPLE ADDRESS: (SAME AS 13)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 MINUTES

DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE — 5 DAYS

DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA — 15 DAYS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DEHYDRATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-12, 1986, to 1-29, 1986, that (I) (we) last saw the deceased alive on 1-29, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did not) view the body after death.

22b. SIGNATURE: KMithani — DEGREE: MD — ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/30/86.

22d. PHYSICIAN'S NAME (TYPE OR PRINT): KAMRUDIN MITHANI

22e. ADDRESS: 131 S. UNION AVE. HAVRE DE GRACE MD 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 2-1-86

23c. NAME OF CEMETERY OR CREMATORY: WEST NOTTINGHAM

23d. LOCATION CITY OR TOWN: Colora COUNTY: Cecil STATE: Md

24. FUNERAL DIRECTOR NAME / ADDRESS: R T FOARD FUNERAL HOME Rising Sun MD

25a. DATE REC'D. BY REGISTRAR: FEB 04 1986

25b. REGISTRAR'S SIGNATURE: Sylvia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

024012

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 002108

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST PEARL MIDDLE ADDIE LAST STANLEY

2a. DATE OF DEATH MONTH DAY YEAR 01-18-86

2b. HOUR 6:59 P.M.

3. SEX Female

4. RACE Caucasian

5. DATE OF BIRTH MONTH 04 DAY 02 YEAR 1917

6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. IF UNDER 1 YEAR MONTHS — DAYS — IF UNDER 24 HRS. HOURS — MIN. —

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑

9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.

10. CITY OR TOWN OF DEATH Havre deGrace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brevins Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medicine Aide

12b. KIND OF BUSINESS OR INDUSTRY Nursing Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland

13b. COUNTY Harford

13c. CITY OR TOWN Aberdeen

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE #11 Wright's Trailer Park 21001

14. FATHER'S NAME FIRST Franklin MIDDLE -- LAST Turpin

15. MOTHER'S MAIDEN NAME FIRST Tynesty MIDDLE -- LAST Quesenberry

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no (IF YES, GIVE WAR OR DATES) --

16b. SOCIAL SECURITY NO. 232-56-1870

17. INFORMANT Rev.Tracey A. Stanley, 2006 Creswell Road ADDRESS Aberdeen,Md. 21001

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac decompensation

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cerebrovascular insufficiency

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-15 '85 to 1-18 '86 that (I) (we) last saw the deceased alive on 1/13 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE DEGREE ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 1/18/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAMAKAWA M.D.

22e. ADDRESS 318 So Union Ave. Havre de Grace Md. 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE Jan.21,1986

23c. NAME OF CEMETERY OR CREMATORY BelAir Memorial Gardens

23d. LOCATION CITY OR TOWN Bel Air COUNTY Harford STATE Md.

24. FUNERAL DIRECTOR NAME Howard K. McComas III ADDRESS Abingdon,Md. 21009

25a. DATE REC'D BY REGISTRAR JAN 22 1986

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

009194

STATE OF MARYLAND 86 002109
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Roy MIDDLE Eugene LAST Swam | | 2a. DATE OF DEATH MONTH DAY YEAR January 1 1986 | 2b. HOUR 3:30 pm |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR July 21, 1916 | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS; IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. |
| 10. CITY OR TOWN OF DEATH Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | 12b. KIND OF BUSINESS OR INDUSTRY US Gov't. |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | |
| 13a. STATE Maryland | 13b. COUNTY Harford | 13c. CITY OR TOWN Aberdeen | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] |
| 13e. STREET ADDRESS / ZIP CODE 751 Mahan RD/21001 | | | |
| 14. FATHER'S NAME FIRST James MIDDLE Henry LAST Swam | | 15. MOTHER'S MAIDEN NAME FIRST Mamie MIDDLE Walter LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | (IF YES, GIVE WAR OR DATES) WW II | 16b. SOCIAL SECURITY NO. 217-07-1068 | 17. INFORMANT John H. Swam, ADDRESS 2421 Rosks RD, Forest Hill, MD 21050 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CARDIORESPIRATORY FAILURE | 24 hrs. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | SEPTICEMIA | 24 DAYS. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | EMPYEMA OF GALL BLADDER | 10 DAYS. |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DIABETES MELITUS, CARDIOMEGALY. ASHD.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION 12 23 85 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED EMPYEMA OF GALL BLADDER | 20a. AUTOPSY? YES [ ] NO [✓] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11-19 19 85 to 1-1 19 86 that (I) (we) last saw the deceased alive on 1-1 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE Mithani | DEGREE M.D. ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [✓] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED 1/1/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KAMRUDIN MITHANI | 22e. ADDRESS 131 S. UNION AVE. HAVRE DE GRACE MD 21078 | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Jan. 6, 1986 | 23c. NAME OF CEMETERY OR CREMATORY Center Methodist Cem. | 23d. LOCATION CITY OR TOWN Forest Hill, COUNTY Harford, STATE MD |
| 24. FUNERAL DIRECTOR NAME Tarring Funeral Home, ADDRESS P.A. Aberdeen, MD, 21001-3390 | | 25a. DATE REC'D BY REGISTRAR JAN 7 1986 | 25b. REGISTRAR'S SIGNATURE |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

030037

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 0 2 1 1 0

REG. NO.

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH | DAY | YEAR | 2b. HOUR |
|---|---|---|---|---|---|---|
| Mabel | Estelle | Thompson | 1 | 25 | 86 | 9 P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIR. DAY) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN. |
|---|---|---|---|---|---|
| Female | White | July 7 1902 | 83 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARITAL STATUS | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Virginia | USA | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | Harford County MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Fallston | Fallston Gen. Hosp. | Presswoman | Clothing - |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Maryland | Baltimore | Jarrettsville | YES ☐ NO ☒ | 3874 Saybrook Ct., 21084 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| James | | Webb | Chloe | | Pittman |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | - | 212-05-9552 | George G. Thompson | 4933 Eastwood Ct., 21043 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): HYPERTENSION

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| ☐ | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 1/25, 19 86, to 1/25, 19 86, that (I) (we) last saw the deceased alive on 1/25, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Dante U. Monakil MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 1/26/86 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| DANTE U. MONAKIL, MD. | DARLINGTON, MD 21034 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
|---|---|---|---|---|---|
| Burial | 1/28/86 | Lorraine Park Cem. | Woodlawn | Balto. | Md. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Martin D. Lawson | 10 W. Padonia Rd. | JAN 28 1986 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 021 11

035100

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please file Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) MARIE JOHANNA VALIS / Marie Johanna Valis | | 2a. DATE OF DEATH MONTH DAY YEAR: 1-28-86 | 2b. HOUR: 10:49 PM |
| 3. SEX: Female | 4. RACE: Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR: April 2, 1911 | 6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD. |
| 10. CITY OR TOWN OF DEATH: Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER | 12b. KIND OF BUSINESS OR INDUSTRY: - |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE |
|---|---|---|---|---|
| Md. | Harford | Bel Air | YES ☐ NO ☒ | 117 Condo E. Donzen Drive 21014 |

| 14. FATHER'S NAME (FIRST, MIDDLE, LAST) | 15. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST) |
|---|---|
| Maximillian Vicen | Marie Koudelka |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | 212-74-1199 | Joan Jirsa (dghtr) | 1608 Creston Drive, Forest Hill, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest — 21050

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD.

DUE TO, OR AS A CONSEQUENCE OF (c) Ca of Tongue.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE |

22a. I certify that (I) (this hospital) attended the deceased from 8-1, 19, to 86, 19, that (I) (we) last saw the deceased alive on 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|---|
| | MD | | |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| V. S. NAER | 211B Bel Air Road Fallston MD 21047 |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE) |
|---|---|---|---|
| Burial | 2/1/86 | Gardens of Faith | Baltimore Md. |

| 24. FUNERAL DIRECTOR (NAME, ADDRESS) | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, Md. 21236 | JAN 31 1986 | [signature] |

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

042056

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the remaining papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual circumstances, in no event, the medical examiner must be notified at once.

BP_____

DHMH - 16 25M
(VR A 15 (4) ) 9/74

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

86 02112

REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Kemper C. Vest | | 2a. DATE OF DEATH MONTH DAY YEAR: Jan. 28, 86 | 2b. HOUR: 10 30 A.M. |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: 2 11 1911 | 6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Elgood, W. Va. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford Co. MD. |
| 10. CITY OR TOWN OF DEATH: Joppa, Md. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1112 Old Mt. Rd. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired | 12b. KIND OF BUSINESS OR INDUSTRY: M. Marietta |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE: Maryland | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Joppa | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 1112 Old Mt. Rd. 21085 |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST / MIDDLE / LAST: George Vest | | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Fannie Whitaker | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 234-20-4010 | 17. INFORMANT: Mrs. Dorothy Vest, ADDRESS: 1112 Old Mt. Rd. Joppa, Md. 21085 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Kermit P Bonovich MD | DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 1/30/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): Kermit P. Bonovich, M.D. | 22e. ADDRESS: 754 Hickory Ave; Bel Air, MD | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Feb 2, 1986 | 23c. NAME OF CEMETERY OR CREMATORY: Elgood Cem. | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Elgood Mercer Co. W. Va. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: E.F. Lassahn, 11750 Belair Rd. Kingsville, Md 21085 | | 25a. DATE REC'D BY REGISTRAR: FEB 05 1986 | 25b. REGISTRAR'S SIGNATURE: [illegible] |

031119

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 02113

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Elizabeth MIDDLE Leticia LAST Ward | | 2a. DATE OF DEATH MONTH 1 DAY 27 YEAR 86 | 2b. HOUR 9:10 p M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH April DAY 19 YEAR 1914 | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. |
| 10. CITY OR TOWN OF DEATH Fallston, MD | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hosp. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) L.P.Nurse | 12b. KIND OF BUSINESS OR INDUSTRY Hospital |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE Maryland | 13b. COUNTY Harford | 13c. CITY OR TOWN Bel Air | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS / ZIP CODE 438 Moores Mill Road 21014 |

| | | | | | |
|---|---|---|---|---|---|
| 14. FATHER'S NAME FIRST George | MIDDLE Washington | LAST Collenberg | 15. MOTHER'S MAIDEN NAME FIRST Lettie | MIDDLE E. | LAST Smith |

| | | | |
|---|---|---|---|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | (IF YES, GIVE WAR OR DATES) -- | 16b. SOCIAL SECURITY NO. 214-14-9159 | 17. INFORMANT Robert Keenan, ADDRESS 438 Moore Mill Road, BelAir, Md. 21014 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Asystole

DUE TO, OR AS A CONSEQUENCE OF (b) Acute MI — 24 Hours

DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 1/26, 19 86, to 1/27, 19 86, that (I) (we) last saw the deceased alive on 1/27, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE [signature] | DEGREE MD | ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED 1/27/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marilyn J Macvay | | 22e. ADDRESS Fallston General Hospital | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Jan. 30, 1986 | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | 23d. LOCATION CITY OR TOWN Baltimore, COUNTY Balto, STATE Md. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS Howard K. McComas III, Abingdon, Md. 21009 | | 25a. DATE REC'D. BY REGISTRAR JAN 29 1986 | 25b. REGISTRAR'S SIGNATURE |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours [illegible] page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical [illegible]

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

017060

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove easily. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, other than one event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

BP 02114

REG. NO.

1 - FOR STATE REGISTRAR (Mr. Nathan Lloyd WEAVER)

1. DECEASED NAME (TYPE OR PRINT) — FIRST (3) Weaver; MIDDLE (1) Nathan; LAST (2) Lloyd

2a. DATE OF DEATH (MONTH DAY YEAR) (January 4, 1986): Jan-4/86

2b. HOUR: 05:40 A.M.

3. SEX: Male

4. RACE: Canc.

5. DATE OF BIRTH — MONTH 8 DAY 16 YEAR 1890

6. AGE (IN YEARS LAST BIRTHDAY): 95 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): 99

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Fallston (2047)

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Artist

12b. KIND OF BUSINESS OR INDUSTRY: Painter

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Harford Co.

13c. CITY OR TOWN: Darlington (21034)

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 3056 Harmony Church Road 21034

14. FATHER'S NAME — FIRST Benjamin; MIDDLE Andrew; LAST Weaver

15. MOTHER'S MAIDEN NAME — FIRST Nora; MIDDLE; LAST Whittington

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES-Navy (IF YES, GIVE WAR OR DATES): 1907-1912

16b. SOCIAL SECURITY NO.: 218-07-9270

17. INFORMAN (Son) 592-7091 Mr. Vernon L. Weaver — ADDRESS: 11714 Cedar Lane, Kingsville, Maryland 21087

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bradycardia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: immediate

DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary edema — 24 hrs

DUE TO, OR AS A CONSEQUENCE OF (c) Acute myocardial edema. — 48 hrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/1, 19 86, to 1/4, 19 86, that (I) (we) last saw the deceased alive on 1/4, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Douglas L. Mallory M.D. — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/4/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Douglas L. Mallory

22e. ADDRESS: Fallston General Hosp. Fallston, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: January 4, 1986

23c. NAME OF CEMETERY OR CREMATORY: R.A. Fettis & Co. Crematory

23d. LOCATION — CITY OR TOWN: West Chester; COUNTY: Chester Co.; STATE: Pennsylvania (Zip Code 19380-4286)

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: 50 W. Broadway & Williams St., Bel Air, Maryland 21014

25a. DATE REC'D. BY REGISTRAR: JAN 10 1986

25b. REGISTRAR'S SIGNATURE

024193

86 02115

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Bessie MIDDLE: Caroline LAST: White

2a. DATE OF DEATH — MONTH DAY YEAR: Jan. 11 1986

2b. HOUR: 8:05 P.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH DAY YEAR: 12 16 1904

6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Balto. Md.

7b. CITIZEN OF WHAT COUNTRY?: U. S. A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Home maker

12b. KIND OF BUSINESS OR INDUSTRY: House keeping

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Harford

13c. CITY OR TOWN: Joppa

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 802 Foxwell Rd. 21085

14. FATHER'S NAME — FIRST: Edward LAST: Harryman

15. MOTHER'S MAIDEN NAME — FIRST: Florence LAST: Amoss

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 219-60-6181

17. INFORMANT: Mrs. Eleanor L. Fisher, Joppa, Md. 21085 ADDRESS 802 Foxwell Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) A. Arrhythmia c metastasis

DUE TO, OR AS A CONSEQUENCE OF (b) Anemia thrombocytopenia

DUE TO, OR AS A CONSEQUENCE OF (c) Debt

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-30, 19 85, to 1-11, 19 86, that (I) (we) last saw the deceased alive on 1-11, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Richard Yun DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/12/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Tom D Yun

22e. ADDRESS: Havre de Grace, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1-14-1986

23c. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery

23d. LOCATION — CITY OR TOWN: Baltimore COUNTY: Maryland STATE

24. FUNERAL DIRECTOR — NAME ADDRESS: E.F.Lassahn, 11750 Belair Rd. Kingsville, Md. 21087

25a. DATE REC'D. BY REGISTRAR: JAN 20 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Copies 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

016134

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 02116

REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Viola MIDDLE A. LAST Wirsing | | 2a. DATE OF DEATH MONTH Jan DAY 9 YEAR 1986 | 2b. HOUR 6:48 P.M. |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH April DAY 7 YEAR 1904 | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. |
| 10. CITY OR TOWN OF DEATH Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | 13b. COUNTY Harford | 13c. CITY OR TOWN Aberdeen | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS / ZIP CODE 848 Aldino Stepney Rd. 21001 |
| 14. FATHER'S NAME FIRST PETER MIDDLE LAST Wirsing | | 15. MOTHER'S MAIDEN NAME FIRST EMMA MIDDLE LAST Lieske | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. 212-01-5887 | 17. INFORMANT Joseph Gallien, 848 Aldino-Stepney Road — ADDRESS Aberdeen, MD. 21001 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory Arrest — About 1 hour

DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrhythmia / Acute Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Atherosclerotic Heart Disease

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 1983, 19 1-9-86 to 1/9, 19 86, that (I) (we) last saw the deceased alive on 1/9, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE [signature] | DEGREE MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED 1/9/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAZATIN, MANUEL | 22e. ADDRESS PO Box 579 St Law St, Aberdeen, MD 21001 | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 13 January 1986 | 23c. NAME OF CEMETERY OR CREMATORY St. Pauls Lutheran Cem. | 23d. LOCATION CITY OR TOWN Aberdeen COUNTY Harford STATE Maryland |
| 24. FUNERAL DIRECTOR NAME / ADDRESS Tarring Funeral Home, P.A., Aberdeen, MD. 21001-3399 | | 25a. DATE REC'D. BY REGISTRAR JAN 13 [illegible] | 25b. REGISTRAR'S SIGNATURE [signature] |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

017064

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 2 1 1 7

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Willie MIDDLE: L. LAST: Wishard | | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH DAY YEAR: 1-5 1986 | 2b. HOUR: M |
| 3. SEX: F | 4. RACE: W | 5. DATE OF BIRTH MONTH DAY YEAR: 2 28 09 | 6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN. |
| 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 1-7 1986 | 2d. HOUR: 5:45P M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD |
| 10. CITY OR TOWN OF DEATH: Street | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1140 Priestford Rd. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Street | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS: 1140 Priestford Rd. 21154 |
| 14. FATHER'S NAME FIRST: William MIDDLE: LAST: Mulligan | | 15. MOTHER'S MAIDEN NAME FIRST: Alice MIDDLE: A. LAST: Ayers | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 219-10-1930 | 17. INFORMANT: Personal papers | ADDRESS: Milton Wishard 1140 Priestford Rd, Street, Md |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Heart Disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☐ |
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 1-7-86

EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D. ADDRESS 464 Alliance St. HavreDe Grace, MD

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation | 23b. DATE: Jan.8,1986 | 23c. NAME OF CEMETERY OR CREMATORY: Yorktowne | 23d. LOCATION CITY OR TOWN: York COUNTY: York STATE: Penna |
| 24. FUNERAL DIRECTOR NAME: John H. Harkins ADDRESS: 600 Main St., Delta, Pa., 17314 | | 25a. DATE REC'D. BY REGISTRAR: JAN 10 1986 | 25b. REGISTRAR'S SIGNATURE: [signature] |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP_____ DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 86 02118

0351401

1. DECEASED NAME (TYPE OR PRINT): FIRST John; MIDDLE Ludwig; LAST Zubalik Jr.

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ — MONTH 1 DAY 28 YEAR 1986

2b. HOUR M

3. SEX: M

4. RACE: W

5. DATE OF BIRTH: MONTH 1 DAY 9 YEAR 16

6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 1 DAY 28 YEAR 1986

2d. HOUR 8:30 a M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NY

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Bel Air

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 803 Coconut Ct. Apt. I

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Examiner

12b. KIND OF BUSINESS OR INDUSTRY: Md. State Motor Veh.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Harford

13c. CITY OR TOWN: Bel Air

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 803 Coconut Ct. Apt. I 21014

14. FATHER'S NAME: FIRST John; MIDDLE L; LAST Zubalik Sr.

15. MOTHER'S MAIDEN NAME: FIRST Stephanie; MIDDLE Pavucek; LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): yes (IF YES, GIVE WAR OR DATES): WW II

16b. SOCIAL SECURITY NO.: 213-07-9321

17. INFORMANT: (Wife) Anna Zubalik - same address

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: L Renjel M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 1-28-86

EXAMINER'S NAME (TYPE OR PRINT): Luis E. Renjel, M.D. ADDRESS: 464 Alliance St. Havre De Grace, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1/31/86

23c. NAME OF CEMETERY OR CREMATORY: Gardens of Faith

23d. LOCATION: CITY OR TOWN Baltimore; COUNTY; STATE Md.

24. FUNERAL DIRECTOR: NAME Schimmek Funeral Home, Inc. ADDRESS 9705 Belair Rd., Balto. Md. 21236

25a. DATE REC'D. BY REGISTRAR: JAN 31 1986

25b. REGISTRAR'S SIGNATURE: Celia Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ADDITIONAL TIME IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. RETAIN PAGE 5 FOR YOUR FILE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP DHMH 17 (VR A15 ME (5))